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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Family Life in a Changing World

Communicative Problems in Children

Building Homemaker Services

A Joint-Interview Technique

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◀

NOW AN URBANITE this child of New York's streets once lived in a rural section of Puerto Rico. What his future holds will depend a great deal on the ability of his parents to give him a warm family life in spite of the shocks and confusions they face in adjusting to the city's pace and cultural expectations. The effects on family life of this and other types of change taking place today are discussed in the lead article in this issue.

◀ *the authors*

Before taking his present position 2 years ago, Gunnar Dybwad was for 6 years director of the Child Study Association in New York. Previously he served for 8 years as director of child welfare for the State of Michigan. In 1949 and again in 1950 he went to Germany as a child-welfare consultant, first for the Secretary of the Army and then for the Department of State. He is a graduate of the New York School of Social Work.

Before joining the Children's Bureau staff 2 years ago, Mortimer Garrison was chief psychologist at the Training School at Vineland, N. J., a private school for the mentally retarded. Previously he was assistant professor of psychology at the University of Pennsylvania. He received his doctoral degree from Columbia University.

William G. Hardy (left) and Miriam B. Pauls (right) have been associated in their work for children with communicative disorders for the past 10 years. They are respectively associate and assistant professors of otolaryngology at the Johns Hopkins schools of medicine and public health.

Myrtle Wolff began her professional career as rural child-welfare worker in Illinois. Before going to her present position in North Carolina in 1954, she was for 13 years with the Illinois Department of Public Welfare in a variety of capacities—child-welfare consultant, child-welfare supervisor, regional representative, administrative assistant, superintendent of the girls' training school. She is a graduate of Chicago's School of Social Service Administration.

In the summer of 1957 Eleanor S. Wertheim took a 1½ year leave of absence from her position in Australia to go to the United States and Europe to study and observe recent developments in child guidance, psychiatry, and research. She spent a year as a Fulbright grantee studying at the Graduate School of Psychology, University of Michigan and working at the Hawthorn Center in Northville. She was educated at the Sorbonne in Paris and at the University of Melbourne.

For 5 years, 1952–57, Donald W. Jackson, as executive of the Valley Children's Services and its predecessor the Valley Boys' Ranch in Harlingen, Tex., stimulated and participated in the changes his article describes. A psychologist with training in social work, he was for a year assistant director of the Texas Youth Council before becoming director of the Corsicana State Home for dependent children.

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How rapid trends toward industrialization and urbanization are affecting . . .

FAMILY LIFE IN A CHANGING WORLD

GUNNAR DYBWAD, J. D.
Executive Director, National Association for Retarded Children.

IN RECENT YEARS the family has become the subject of much controversy. Certain sociologists have for the past several decades been writing it off as a doomed institution, while others regard it as the bulwark around which human existence can forever reorient itself for new tasks and challenges. What actually is happening to family life and parent-child relationships in this churning cauldron of change that is the world today?

No one can have enough information to assess the conditions of family life in all the world today. But it is possible to sketch broadly some of the implications of those two complementary trends, industrialization and urbanization, on the family as an institution, on its members, and finally on its supporting services.

Two years ago the Eighth International Conference of Social Work devoted its entire time to a consideration of industrialization. Perhaps the broadest and most significant finding of that international gathering was the realization that industrialization was moving ahead steadily and relentlessly, leaving no part of the globe untouched.[1]

Wherever industrialization develops, it inevitably deeply influences existing family life. For one thing, it rearranges time-honored work processes: what was once hard labor requiring the efforts of several men becomes an easy operation that even a child can handle. What once had to be obtained far away from the home now is available in the home. Conversely, work that formerly was done in the home now is performed a long distance away, sometimes requiring separation of the family, or, in other instances, is done at home in a new type of sweatshop which requires members of a family to work in shifts around the clock.

Urbanization

Urbanization invariably follows industrialization. A United Nations conference on the mental-health aspects of urbanization, sponsored by the World Federation for Mental Health in 1957, noted a sequence of "industrialization—urbanization—mental-health problems," the last being largely related to the family and its functioning in a new social situation.

There, too, it was reported that a very frequent, though not universal, aspect of urbanization was the disappearance of the large *extended* family in favor of the small, *nuclear* family of parents and children, a family more vulnerable to emergencies, and generally lacking the framework for a close relationship between the generations.[2] This change from the extended to the nuclear family has accentuated the worldwide housing shortage.[3]

Moreover, there is today in many parts of the world no longer any clear-cut line of demarcation between urban and rural areas: in addition to a vast increase of suburban localities independent of the cities they adjoin, there are large developments in rural areas which have at least some distinctly urban characteristics. While these developments proceed

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Based on a paper presented at the World Child Welfare Congress, Brussels, July 1958.

differently in different places, the prediction is that within four decades, one quarter of all the people of the world will live in cities of 100,000 people or more.[4]

The task ahead is clear. This is to find ways of developing industrialization and urbanization that will strengthen rather than weaken family life—to channel the new forces to safeguard essential cultural aspects of the peoples affected. This presupposes a realistic facing of the future rather than an attempt to stop the clock.

Migration

An inevitable by-product of industrialization and urbanization is *migration.* Just as the last of the nomadic peoples begin to develop permanent settlements, the rest of mankind seems bent on moving about in search of greater economic rewards. This brings the family the disadvantage of "uprootedness," the danger of being "lost" in a new location, the separation from cultural traditions and their inherent moral support.

Another disturbing result of movement is the absentee father, whose work takes him away from his family for weeks or months at a time, or for so many hours during the week that he becomes merely "an overnight boarder" in his own home. Of course, this phenomenon is not entirely new but it has never been considered a constructive one for the family, and it is becoming more and more common. Julia Henderson has pointed out that this calls for concern about the father's existence as well as the family's he leaves behind: If the separation is one that extends over weeks and months then a new problem may arise from sexual relationships he may form at his place of work, resulting in additional "family" responsibilities.[2]

Problems of migration affect all income groups. In India, for instance, mobility is particularly prevalent among the lower economic groups in their search for better jobs and wages, while the upper income groups tend to stay on the land they own. In the United States, on the other hand, in recent years administrative and technical employees of large corporations especially have been required to move their families from place to place.

All these developments have brought to families feelings of confusion and insecurity. As old cultural patterns prove inadequate to modern needs, as migration brings families in contact with new customs and ways of life, as the greater flexibility of young people allows children to adjust to new situations more speedily than their elders, parents become puzzled and bewildered. Through newspapers, picture journals, films, radio, and television, children pick up quickly, if somewhat superficially, more general information than individuals in former generations could gather in a lifetime.

Perhaps the factor making the greatest impact on family life today is the sheer pace of technical progress. Until a few decades ago, the ever-changing ways of living proceeded slowly enough to permit a gradual transition from one generation to the next. Parents could form a fairly accurate picture of the circumstances under which their children would live and could guide them accordingly. Today parents find increasing difficulties in adjusting to the fact that the younger generation often has knowledge, skills, and global orientations which they the parents do not adequately comprehend. Still somehow aware of their age-old role as bearers of cultural traditions, they feel a growing uncertainty as to how far they can impose their own standards on children who are destined to live in a world they cannot visualize.[5]

This does not mean that parents have abdicated their responsibilities. Undoubtedly, most parents still are as concerned as ever with their children's welfare, but they wonder how they can lead when they sense so much their own need for direction. Industrialization and urbanization are less threatening to the family as an institution than to the traditional structure within the family. In some instances this has led to exaggerated exhortations to parents to reinstitute authoritarian patterns of family hierarchy and family discipline.

Individuals and Roles

In considering the effects of industrialization and urbanization on the family's members, one must be ever mindful of the need for social policies to focus on serving and improving conditions for the family group as a whole. In the past some of us have concentrated too much on what we thought was helpful to the child and not enough on what was appropriate to the child *as a member of his family.* As a matter of fact even this focus is not broad enough, for we must also think in a larger dimension of the family's place in the community.

Nevertheless, it is also important to look at family structure in terms of intrafamily relationships—parent-child, husband-wife, brother-sister—and of the parent or the child as an individual in his own right.

It is the individual who can and must make the most important contribution toward the improvement of social conditions.

The emphasis on the individual as a human being in his own right as well as a member of the family unit seems particularly important in this day of mass movements, mass housing, mass media of communication, mass employment, and mass education. Indeed, with the rapid increase in urbanization we should expect a greater emphasis on the individual since one of the strange contradictions about urban development is that while, on the one hand, it submerges the individual and his family in a mass, it at the same time affords each person a greater opportunity to establish social status away from his family.

This calls for consideration of the concept of role, developed by the sociologists. According to this concept, each individual can be regarded as holding a status to which are attached certain rights and duties. As he puts these into effect he performs his "role." In this area of role performance considerable controversy exists regarding present-day practices in family life and parent-child relationships. The focus of this controversy is on the question as to whether recent developments have tended to blur the appropriate roles of the male and female members of the family, thus endangering the effectiveness of parent-child relationships by creating confusion in the mind of the child and of the parent as well.

The psychoanalyst Bruno Bettelheim has developed this thesis in an article entitled "Fathers Shouldn't Try To Be Mothers." [6] But then the question arises: what does a father do and what does a mother do? For some people the answer is easy: the father acts out and thereby interprets the role of a male; the mother, the role of the female. Yet, this provokes the further query: what is male and what is female?

Many attempts have been made to answer this most basic question. Morris Zelditch, Jr.,[7] for instance, presents a thesis which can be summarized thus: In the social system that evolves within the nuclear family two basic roles can be differentiated, instrumental leadership and expressive leadership. Instrumental leadership, which involves primarily a manipulation of the external environment and consequently a good deal of physical mobility, is performed by the father, while the expressive leader is the mother, the family's source of security and comfort.

That there are universal aspects of male and female roles is an unassailable contention of contemporary anthropological research. However, the problem is how far beyond the obvious physiological factors there is any sure ground for claiming basic and universal characteristics. Still more pertinent, however, is the question: To what extent is so definitive an assignment of general roles to the male and female really feasible? Does not science's growing knowledge about other aspects of the human being indicate that such clear lines of demarcation as once were drawn, for instance, between physiological and psychological aspects are becoming less and less distinguishable?

We should be greatly concerned over the far-fetched conclusions which have been drawn from the basic differences between the sexes in regard to the appropriate role of men and women, and more specifically, fathers and mothers. We must face this question squarely and find an orientation which seems appropriate to our era, or else we will not be in a position to plan intelligently for our children and their families and to develop the supporting services they need.

Changing Role Functions

The first way in which many critics of new family developments see violence being done to basic laws of nature is through the work activities of men and women in and about the home. They see life as it was when the man protected the family from enemies and hostile beasts, went out hunting, and plowed the ground, while the woman stayed at home nursing the baby, weaving and sewing, and taking care of their abode. For instance, a distinguished psychiatrist has maintained that it is important for boys to learn that man's role is "to aggressively defend the home." [8]

Actually, of course, industrialization and urbanization frequently remove the man far from the home, leaving the woman or the organized authorities to defend it. Men no longer need to carry arms in countries where industrialization has taken hold. Today physical strength and endurance are measured in many ways. In the United States, statistics show that there the women are the stronger sex, if longevity is a criterion. Moreover, many women are physically more active around the house and do more walking and lifting than their husbands do in the office or at a machine in the factory.

What about the other function of the male, as provider, supplier, or wage earner? Certainly all over

One of the thousands of families in the world today who have recently changed from rural to urban living this American family considerably improved its living standards when the father got a job in industry. Their move from a poverty stricken Indian reservation was accomplished with the help of the Department of the Interior's Bureau of Indian Affairs.

the world men are still predominantly fulfilling these functions. However, today they are not alone in this. Increasingly women, too, are breadwinners, at least for certain periods of their lives. As industrialization and mechanization progress, specific jobs which were formerly the prerogative and indeed one of the distinctions of a man are now held competently and comfortably by women as well. Work outside the home is no longer a distinguishing characteristic of the male.

Actually, one of the consequences of industrialization and the breakdown of the extended family system is that many women are forced to work outside the home just to provide a minimum means of subsistence for the family. However, as urbanization and mechanization progress many women take a job because they seek a fuller life outside the home or because they want to earn money to buy some of the mechanical household equipment which industrialization brings to them. Whether or not a mother *should* work outside the home is a matter of judgment which does not fit into this particular discussion of male and female roles.

The third characteristic of the male role as conceived by some sociologists is of the male as the manipulator of the outside world, the person who participates in public affairs, who represents the family group outside the home. That this is likewise a distinction which is losing its validity is amply attested by the tremendous contributions women all over the world are making to the improvement of public life and community services.

It is important in considering the effect, up to now, of industrialization and related socioeconomic changes in the family and in contemplating future supportive steps on behalf of the family to question seriously those who insist on the maintenance of traditional general patterns of male and female functioning. On the one hand, we should be ready to accept the fact that the radical changes of industrialization, urbanization, and mechanization will at the same time limit and broaden the activity base of both men and women. On the other hand, we should be mindful that social and economic progress, well-directed, can bring forth increasing opportunity for individual expression. It need not be a sign of decay that the concepts of sex roles are less distinct. To the contrary, this should provide broader opportunities for the men and women in the family group to unfold their individual human potentialities.

Those of us concerned with the welfare of children should be more and more concerned with the increasing problems young people face as they contemplate marriage today. Marriage, of course, has always been a serious undertaking, but in former days the support of the large extended family group, the continuing counsel of mother and mother-in-law, the example of other young couples, and finally the existence of clear-cut patterns of conduct and activities expected of men and women provided guidance and helping hands for the young couple. In the industrialized and urbanized society however, which moves away from rigid role patterns and at the same time separates the young couple from the larger family group, more demands are made on bride and groom.

Therefore, it is a cause for concern that at a time when child marriages are on the wane in Eastern countries, in certain highly industrialized Western countries they are being contracted at an increasingly younger age.

Today's New Families

Furthermore. "romantic love" as a basis for marriage is spreading throughout the world. This derives from greater independence of young men and women from their families and more informality or lack of ceremonial custom is choosing the marriage partner. The corollary of this independence is increasing separation or even actual isolation of the new young family from either or both of the parent families.

Western countries, in particular, have been experiencing increases in divorce rates. This would seem to call for more attention and service at the point of engagement and marriage to help the developing new patterns become channeled in constructive lines. Unfortunately, there are too few opportunities where young people about to be married can get this type of counseling. Of course the development of maturity should be nurtured long before the point of marriage, all through the days of education at home and at school.

With all their problems most young couples today, as always, eventually assume parental responsibility. Here again professional controversy has arisen as to proper roles. There is a thesis that early child development involves a "symbiosis," a physiological as well as psychological living together of the mother and her infant child for many months after birth, centering on the mother's nursing of the child; and that in this relationship the father can only be an intruder. Some distinguished authorities go so far as to say that during his first 6 months, or even his first 2 years, a child should be in the exclusive care of his mother.[9]

This viewpoint gained considerable strength about 10 years ago after some reports on the relationship between mothers and infants in certain primitive societies were published. However, Margaret Mead, one of the foremost students of primitive culture, insists that insights gained from studies of primitive people must be applied in forms appropriate for modern industrial society and warns against taking as a model for our current urban society the primitive mother who delivers without help and breast feeds easily. She warns against allowing overemphasis on the ancient biological responses of lactation to obscure the appropriate tasks of the 20th-century parents. Experience in some eastern societies, she reports, has shown that this close and exclusive tie between mother and infant results not only in a comfortable sense of security, but also in a fear of, and inability to meet, strangers—a response appropriate in a past culture, but no longer appropriate today.[10]

There is of course a most meaningful relationship between the mother and her infant child, but it seems likely that instead of losing its value, it is actually enhanced when it includes others, particularly the father and other children in the family.

Infant care has been the subject of controversy in another direction also. Some critics hold that it is an effeminate affectation for fathers to become involved in the physical care of their infants, helping to clean them, feed them, and put them to sleep. They see in such fathers a particularly serious confusion of role conduct which will result in retarding or preventing the infant's image of the father as the strong, aggressive leader, and thereby interfere with the development of a sound family structure.

The research available in the area of infant care is overwhelmingly based on investigations of mother-child relationship. However, it should be stressed that we have at least the beginnings of research on the effect of father deprivation on infants, and that these preliminary results would support the thesis that infants need contact with their fathers as well as with their mothers.

Here again it is important to emphasize the necessity of recognizing individual differences. Not all fathers find pleasure in taking care of the physical needs of their infants; but neither do all mothers find pleasure in such tasks, though the great majority do, no doubt. No one suggests that *all* fathers *should* take turns with their wives in caring for infant children, but certainly more good than harm seems likely to result from tangible, direct relationship between infant and father from the very beginning of the child's life. Indeed, in some countries efforts are made to help the expectant father to understand the process of pregnancy so that this will be a period of sharing with his wife rather than a period of increasing separation. Undoubtedly, many people will have difficulty in accepting this view, because for too long we have allowed the lives of individuals as well as nations to be governed by principles of an authoritarianism which depended on the father figure as its particular symbol.

New Patterns Needed

Authoritarianism still manifests itself in patterns of family life in most countries of the world, including the United States. This fact should force persons in child-welfare work to move beyond their own particular functions into the market place of public opinion to share their knowledge and insights with others. Time is running out on us. What kind of concept do we want our children to have of man's family and the family of man?

Ten years ago, Brock Chisholm said:

> It is quite clear that we must learn to live in peace with each other throughout the world. If we do not do so, there is

> little prospect that our children will finish their lives according to the statistical probabilities on which the life insurance companies depend . . . .
>
> It is well worth our while to look at the way we were brought up, the way we were developed, and hope to find out what is wrong with us so that we may prevent our children from assuming those same patterns.
>
> . . . There are enormous numbers of adults in the world who lack security, who have lacked security from infancy, and because of that lack of security are available as followers specifically of those people who have excessive needs for power . . . It becomes clear that the first necessity is to produce a degree of security in small children that will make it unnecessary for them to search for security in peculiar and unworkable ways when they become adults.[11]

To this ringing appeal has come a recent echo from India through Manu Meta Desai, professor of social work at the Tata Institute in Bombay, who writes:

> The major responsibilities of Indian parents today therefore lie not in helping their children to accept and follow traditional ways and standards but to help them evolve a new synthesis between the old and the new, with a minimum of strain and a maximum of ease, as well as to impart in them a sense of loyalty and responsibility to groups and peoples far beyond the limits of their narrow family caste and community life.[12]

First we must emphasize the importance of developing in the child a sense of human dignity and worth. This of course can only be a reflection of the human dignity the child sees in his father and mother. An infant gets his feeling of security from the affectionate and tender care of his parents—not from a realization that father is a person of authority and strength, who can militantly defend the home.

Next, we must avoid passing on to children all the prejudices, choices, and cherished biases by which adults subtly lead children to discriminate against others because they are poor, or have a different shade of skin, or worship in a different temple, or happen to be physically or mentally handicapped in some way. And that means that we must help our children early in life to meet with others beyond the family circle, in play groups or nurseries where there are not just those who are alike, but also others who are different.

Conflict in Generations

Of course there will aways be some conflict between generations. Age differences make this as natural as the friction in moving parts of a machine. But there is more than that to the conflict between the generations today. Young people are deeply confused by the inconsistencies and insincerity of their elders. We push them ahead in adolescence, yet hold them back as they reach the threshold of adulthood. We surround them as children with sexual stimulation in sound, print, and picture, yet try to impose on them rigid taboos against sexual behavior in their adolescence. We open vistas of a technological wonder-world of the future, and at the same time seem to be racing down the road toward world destruction. We are quick to complain when young people cannot get along in the new-fashioned world, but show our own limitations by recommending "old-fashioned discipline" for their problems.

Suggestions for Services

What are some of the ways of strengthening family life for bridging the gap between the past and the future successfully?

First, we must always be mindful that millions of children in this world still do not have enough to eat.[13] While we are considering the psychological needs of children, we must never for one minute forget the urgency of the world's hungry children. Their needs must be met through emergency aid and farsighted economic planning.

Second, parent education must become a wider concern. Groups of parents meeting to learn about child care have been spreading rapidly in Europe and America for the past few years. But at the same time considerable opposition to such groups has arisen from professional persons, some of whom are too impressed with their own psychotherapeutic skills to recognize the possibilities of an educational program; and some of whom are justifiably reacting to programs so inferior as to be of potential detriment.

However, under competent leadership parent education can be a most important tool in helping parents come to a better understanding of themselves and their children. Might it not be that in the past many parents responded poorly to child-welfare programs because no effort was made to help them understand their children's needs—the same needs which the services were trying to meet?

Third, we should think a great deal more about wide-scale parent participation in the initiation, policy formulation, promotion, and even administration of needed services. Too long, perhaps, have child-welfare workers looked upon the parents of the children in their care as clients rather than as coworkers. In recent years the parents of handicapped children, particularly of mentally handicapped children, have brought forth in several countries legislation, financial support, and services for the handicapped which not long ago few thought feasible and no one even dared to predict.

Such movements present many difficulties for professional persons, but they hold vast potentialities for the well-being of children.

Fourth, the rapid progress of industrialization and urbanization requires a considerable increase in services to support, but not supplant, the family. In order to meet these needs we must constantly reevaluate our services—with courage to discontinue the outdated, with imagination to invent new ones, and with much greater readiness to work with other professions than our own.

Above all, we must make sure that we do not through our own organizations continue traditional patterns, such as authoritarianism or prejudice, not suitable for our era. Do we in our approach to adolescents implicitly perpetuate such patterns in family life?

Fifth, we badly need careful, large-scale research projects involving countries all over the globe to assess developments everywhere and to make sure that we learn from each other. But before we can undertake these, we need to improve our means of communication by working out common terminology and definitions in the sciencies of human behavior. In order to get support for expansion of services, we are also going to have to do some cost accounting to learn whether or not the services being rendered are truly good public investments.

Some time ago sociologists began to question the sociological validity of the practice of some of the persons who had provided the psychological working hypotheses on which modern social services are based. They pointed out that there often was a considerable cultural difference between social workers and the clients they were trying to serve, resulting in psychological misdirection and misinterpretations. As we who are concerned with services to families and children lean more heavily on the sociologists for our concepts, we might look at the psychological orientation of our sociological collaborators, so that we know to what extent their counsel may be colored by psychological motivations. And certainly we must subject ourselves to the same searching inquiry. If not, we shall certainly fail our children.

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Perhaps the greatest hazard for the public administrator in the welfare field is the theory that makes of administration an end in itself, a triumph of technique over purpose.

Norman V. Lourie to the 1958 forum of the National Conference on Social Welfare.

Increased knowledge about causes, more refined diagnosis, and more effective treatment may result from . . .

RESEARCH TRENDS IN MENTAL DEFICIENCY

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ONLY A FEW years ago persons engaged in research showed little interest in the problems of mental deficiency. While there were exceptions, most research workers were unable to see any direct connection between their work and mental deficiency. They might express interest and recall having heard a lecture on the subject but this was about the limit of their familiarity with this field of research. Sarason and Gladwin,[1] in concluding their survey of psychological and cultural problems in mental subnormality, noted the disappointing quality of research being done in institutions for the retarded and the "disinterest of behavior science departments (psychology, anthropology, sociology, psychiatry) in the area of subnormal functioning."

To put it crudely, one might say that mental retardation simply was not popular. Funds, thinking, and personnel have been engaged in other directions. While the desirability of research was recognized by institutional staffs, their geographical isolation from universities and their budget limitations forcing them to focus on pressing service needs have combined to stunt the growth of research and training in the field.

In the past 5 years, effort on the part of the parents affiliated through the National Association for Retarded Children has resulted in considerable stimulation in all aspects of the field, clinical and research alike. It is to their credit that they have recognized the need for research even though they know this implies commitment to a long-term and, more often than not, unspectacular grind. It is well recognized that the complexity of the factors involved in mental retardation requires research in many disciplines if a more adequate understanding of treatment, cause, and prevention is to be developed.

An immediate result of this stimulation has been an increase in the number of projects under way involving the mentally retarded. These range in a broad sense from efforts to provide more trained personnel for work in the field as at George Peabody College [2] to the special diagnostic clinics supported by the Children's Bureau.[3] As part of this general stimulation the National Association for Retarded Children, the National Institute of Neurological Diseases and Blindness, the National Institute of Mental Health, the Association for the Aid of Crippled Children, and the New York Foundation have jointly supported surveys of biological, psychological, and social problems in mental retardation.[4] A project on technical planning in mental retardation being conducted by the American Association on Mental Deficiency, now in its third year, has involved a variety of activities designed to stimulate improvement in research, training, and program development.[5]

These general projects have underscored the necessity of closer association of the institutions with universities and medical schools in order to break down the isolation of the field and to bring in those whose interest in basic research problems will revitalize the concepts used in mental deficiency. Such general ferment will do much to erase the stereotype current in too many minds that the retarded are poor subjects for research and treatment.

The improvement in the amount of work being done may already be noted in the number of abstracts of work in progress reported in the Children's Bureau publication, *Research Relating to Children.*[6] Although purely medical studies that are only indirectly related to mental retardation are usually excluded from this listing, recent issues of the bulletin have cited 87 studies of various types now being carried on.

Within the Department of Health, Education, and Welfare, the Office of Education has contracted for projects in six areas: (1) the definition and identification of the mentally retarded; (2) learning characteristics and responses; (3) language and communication difficulties; (4) teaching methods and procedures; (5) the effects of different types of school organization; and (6) postschool adjustment and other problems. The Office of Vocational Rehabilitation has initiated and proposes to expand a number of projects aimed at investigating ways of effectively rehabilitating the retarded through various means; the use of special workshop training, counseling, and the establishment of "half-way houses" as an aid to the retarded placed in their first employment.

The National Institutes of Health in addition to its training grants is supporting research on the basic etiological factors in mental retardation and allied disorders such as cerebral palsy. These studies range from discrete investigations of metabolic processes to a comprehensive collaborative study in cerebral palsy and other neurological and sensory disorders of infancy and childhood in which data uniformly collected in a number of medical centers throughout the country will be pooled for analysis.

The Children's Bureau through its operating divisions is supporting clinics aimed at early diagnosis and treatment and is attempting to expand and strengthen social services to the retarded through consultation in community planning and the provision of staff development and training opportunities. While the Bureau has no provision for the direct support of research a variety of studies may be expected to develop from this program.[3]

The Behavioral Sciences

In the behavioral sciences an interesting shift may be observed away from concentration on the use of psychological test-score patterns used to delineate subgroups toward studies designed to tease out the specific difficulties which may exist with respect to some achievement, or to determine how a particular treatment may affect individuals in order to know better how to proceed educationally and vocationally.

Woodward and her coworkers [7, 8] at the Lenox Hill Hospital in New York City have reported on their 3-year study of preschool children, emphasizing the importance of psychogenic factors in inhibiting mental growth. Whether or not their efforts at treatment will prove to be successful is not known, but they do focus attention on the necessity for early identification and treatment in children without detectable organic defect. A somewhat similar project being carried on by Kugel and his associates at the University of Iowa is briefly reported in the Here and There section in this issue of *Children.* (See page 35.)

Griffith and Spitz[9] have studied the process of abstraction in high-grade retardates. When such youngsters are asked to give the property common to three nouns they tend to be successful when they have independently been able to define two of the three words in terms of a possible abstraction. That is, if they define chair and table when these are presented in a vocabulary list as "furniture," they may later be able to recognize that chair, table, and bed when presented together are all "furniture." The authors suggest an application of their work in the training of retardates through the teaching of a common description for several types of social behavior. For instance, meaning for the term "bad" might be developed from the association of "bad" with "punishable," or "cause for being returned to the institution" while these terms in turn are related to the specific items "fighting," "lying," and "stealing."

The importance of taking specific handicaps into account in program planning is illustrated by Hunt and Patterson's study of retarded children with visual or auditory perceptual difficulties.[10] When a brain-injured child with a difficulty in auditory perception is asked to sort out a series of pictures so that they illustrate a story to which he is supposed to listen he tends to concentrate on the pictures and blot out the auditory cues. This work has obvious implications for teaching methods and class composition. [See pages 13–16 for further discussion of mentally retarded children with perceptual defects. Ed.]

A method of measuring activity level has been described by Foshee[11] who used it to measure drive strength during simple and complex learning.

While the implications for program and treatment in this study are not immediate, the long-term results from the study of motivation and learning in the retarded should be considerable. McPherson has again reviewed the experimental literature on learning in the mentally retarded.[12] She reports 14 studies meeting her criteria for inclusion since 1948. While this represents a number larger than that reported in the original review, which extended back to 1904, it remains a very small number when it is compared with the mass of studies reported in the general psychological literature. From her review it is apparent that our knowledge of the learning process in the retarded remains fragmentary and confused.

Quantity and Quality

The studies briefly mentioned here can only indicate the diversity of work now being done in the field. Other investigators are evaluating the effects of socio-economic conditions and language barriers in school performance, the effects of the loss of the mother in infancy on growth patterns, and the self-picture of the retarded child in relation to his goals and level of aspiration. This diversity and quantitative improvement does not necessarily mean that better work is being done. However, there are signs of a qualitative improvement both in the kinds of questions being asked and in the experimental designs.

In general, instead of the comparison of groups on some psychological test score or pattern, more effort is being expended to investigate the psychopathology of mental deficiency. With a more specific knowledge of what is amiss in the learning, thinking, problem solving, personality, and socialization of the mentally retarded, it should be possible to make better predictions about success in education and rehabilitation than can be made at the present time from a knowledge of the I. Q. or of the fact that the individual is considered "brain-injured."

While this paper has focused primarily on the behavioral sciences, the same tendency observed there, the introduction of new concepts, and the relating of experimentation to current theory may be seen in other disciplines. Lippman's paper on the significance of heterozygosity for hereditary metabolic errors may be cited as an example of this.[13] This suggests how the application of modern genetic theory and techniques of investigation may shed light on the etiology of retardation in those people who at present are classified as "familial" or "undifferentiated."

With time, it seems inevitable that concepts and theories which have been found fruitful in the laboratories or in other populations than the retarded will be applied to research with the retarded. This in itself will do much to reduce the gap between university and institutional research workers and increase the useful knowledge about mental deficiency.

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ATYPICAL CHILDREN WITH COMMUNICATIVE DISORDERS

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WITHIN quite recent years there has been developed a powerful armamentarium with which to deal at the diagnostic level with the atypical child who has communicative disorders. Granted that much remains to be learned of the etiology and prevention of such disorders—particularly the facts of intra-uterine environment—the various techniques of measurement and description are becoming more refined and make more sense with each advancing year. However, with more and more children being brought through catastrophic perinatal events and maintained in good health, the numbers of multiply-handicapped children have been steadily increasing.

It becomes readily apparent to the student of epidemiology and biostatistics that a large proportion of the children who are atypical—that is, who need special help in development, in learning, and in social and emotional adjustment—have one combination or another of communicative disorders. Something is sufficiently wrong with their hearing, language development, or speech, alone or in combination, so that these disorders in themselves constitute fundamental difficulties in development, in learning, and in social and emotional adjustment.

It has been society's bent to think of these children according to primary and secondary handicapping conditions, and therefore to begin therapy in terms of the so-called primary problem. In many respects, this is an unsettling idea that is only quasi-logical, and probably represents only one among many possible perspectives from which a child may be viewed.

From this perspective, however, one may see retarded children who are deaf, deaf children who have either the athetoid or spastic form of cerebral palsy, spastics with dysarthria (a neural breakdown in the motor speech system), athetoids with aphasia (an organic inability to use or understand words), aphasiac children with crippling skeletal conditions, rheumatoid children with reading disabilities, aphasiac epileptics, schizoid children with aphasia, and many other combinations. Apparently, this matter of labels may determine which of a number of dysfunctions is primary and which is secondary in the child's condition. Again, this is an unsettling idea, particularly when viewed in the light of a general commitment about concern for "the whole child."

A long step forward in clinical management is marked by the development in recent years of group diagnostic teams, wherein many paramedical disciplines are brought together for interaction around the central figure of the handicapped child.

The "integrated cleft-palate diagnostic group" is an example. A typical group includes representatives of pediatrics, plastic surgery, prosthodontics, orthodontics, dental surgery, otology, psychiatry, speech pathology, and social service, with none of these being either primary or secondary in the diagnostic task.[1] Procedural steps in a particular instance result from group appraisal and consensus, all aimed at a single goal, the best development of the child, which means achievement of the best possible communicative status.

Similarly, "diagnostic centers for multiply-handicapped children" are coming into being in a few medical centers. The driving force of this development has been the realization that in many instances of interclinic referral the child may be lost in the shuffle of a busy medical center, with a confusion of followup records and extreme difficulty in checking out the necessary steps in examination and treatment of complex, multiple problems. The larger the hospital, the more apt this is to occur, particularly to children with chronic problems who must be handled at the outpatient medical-care clinic. This is the fault of nobody in particular; it stems simply from the fact that problems of interagency activity and referral, record keeping, distribution, and followup, scheduling or rescheduling, all involve a morass of paper work and rechecking which busy clinicians do not have time to do. It also stems from the shifting nature of a residency staff, the lack of coordination among specialty consultants, the pressures of various acute problems, and a variety of other aspects of the complex of modern medicine.

Complex Handicaps

Like other children, the atypical child with multiple handicaps, including one or more of the communicative disorders, badly needs to be viewed as a "whole child." What does such a view involve?

Child A exemplifies a common problem. She is 31 months old. Her mother had had 4 miscarriages prior to her conception, and during the pregnancy received hormones from the second month and was kept on frequent bed rest. Labor was prolonged; the cord was wrapped around the infant's neck at birth; the baby was cyanotic and was kept in oxygen for 2 days. There were no postnatal infections or diseases.

As the child grew the motor developmental landmarks were somewhat delayed, but not drastically. At 2 years of age, she showed no problem involving balance, but exhibited a slight lack of coordination in handling things. Her parents were uncertain about whether she had responded to sound in early infancy, but had not really become concerned about her hearing ability until she failed to learn to talk. At 31 months she had achieved only a rudimentary gestural language, which was unstable, no understanding of verbal language, and no speech.

Testing gave clear evidence of normal auditory peripheral function, but showed unstable perception of both pitch and loudness. This indicated a disorder of the central auditory pathways with, in all probability, a receptive language problem, aphasia. An extensive neuropsychologic examination confirmed this impression and also produced evidence of lack of central visual coordination in respect to memory for visual patterns. In spite of showing deficiencies in hearing, language, and speech, the examination gave clear evidence of reasonably good intelligence. This was supported by pediatric developmental neurologic examination in which the child showed no obvious symptoms of retardation except in these various sensory-perceptive areas. An electroencephalogram (recording of the brain waves) showed no frank evidence of an epileptic disorder, but gave some indications of hemispherical asymmetry of the brain and a definite slowing of two types of brain waves, the theta and delta waves.

In summary: The child was in good health after a stormy perinatal experience. No symptoms relating to her ears were present; her peripheral hearing mechanism apparently operated within normal range. There was clear evidence of a central auditory deficit. Central visual functions were not normal. There were problems in memory. Language development was aberrant. The electroencephalogram did not present a recognizable diagnostic picture, but was not normal.

What is this problem? Any of the classical labels is scarcely pertinent. The child can hear, but is deaf; she is retarded, but is not basically mentally defective; she can see, but cannot remember visual patterns, nor can she remember auditory patterns in time; she frequently responds to sound, but cannot discriminate what she "hears." Cortical function is obviously affected, but not in any classical form of "brain injury." She shows a slight lack of motor coordination, but not enough to imply cerebral palsy. She has shown no emotional symptoms beyond what would naturally accrue from communicative deprivation. Certainly this child suffers delayed speech, but this term does not describe her problem.

Actually, she has many problems, involving deficits in sensory functions, in perception, in memory, and in learning. She is a multiply-handicapped child, who needs reassessment regularly, a carefully designed program of parent guidance, and, later, a regimen of skillful teaching based on the diagnostic findings. There is no school placement which can be ideal for a child with such problems, except one which includes eclectic procedures and extensive creative teaching.

Unfortunately, this child is not a *rara avis.* In a busy clinic for children with communicative disorders, hundreds of children with these and other related problems are seen each year. They are atypical children, in terms of classical description, and in terms of one another.

A vast amount of attention is being paid these days to cerebral-palsied children. Most if not all of them have one aspect or another of hearing, language, or speech disorder. Some types of cerebral palsy (or, rather, some of the causes of cerebral palsy) offer more predilection than others for specific communicative dysfunctions. Clinical experience shows, however, that it is usually better not to try to draw general conclusions from a type of cerebral palsy about a specific tendency in communication.

Individual Differences

Over the years, for instance, there has come into being the subconcept of "the deaf athetoid." Yet, while it is true that many athetoid children whose condition originated in Rh-factor incompatibility have impaired hearing resulting from a central lesion, it is equally true that some children of this type have entirely different kinds of hearing problems, or are aphasiac or dysarthric. Some have all three kinds of disorders, as do some children with other cerebral problems. All are children with brain injuries, but few lend themselves to traditional classification in terms of communicative problems.

On the surface a child with a cleft lip and palate would seem to present a clear-cut problem. Some do: many do not. All need the services of "the cleft-palate team," but the details of these needs can vary almost indefinitely with differences in developmental and social maturity, intelligence, familial environment, and the many psychosocial interactions that constitute the behaving individual. When the patient is a teen-age girl, who holds her hand over a scarred lip, who has no associations out of the home, and who refuses to go to school, the psychiatrist and the social worker become the most important members of the team. Until their work bears fruit, little else can happen. Then again, many children with cleft palates have fluctuating hearing losses. For many reasons, these children may be difficult to treat. In doing so the otologist and the pediatrician must give a carefully balanced consideration to anatomical, physiological, and psychological factors.

Among the atypical children with communicative disorders there is a large group referred to as "mentally retarded." Here, as usual, the details differ with each child. That he is retarded is usually fairly obvious; why, how, how much, and what he has to build on are questions with quite different answers for each. Many children are mentally retarded and deaf, or mentally retarded and aphasiac, or mentally retarded and blind.

One would expect the deaf, or aphasiac, or blind child to be retarded in several ways, for lack of either hearing, word comprehension, or sight leads inevitably to a large measure of communicative deprivation. It is most important that children who have been impeded in their development by communicative deprivation not be confused with children who are profoundly deficient in their capacities to learn. A vast difference lies between the potential of the child who is biologically deficient in capacity to learn, and that of the deaf or aphasiac child who functions suboptimally because of sensory, perceptive, or mnemonic deprivation.

Another group of children with combined handicaps which are often extremely abstruse, are the so-called "emotionally disturbed." A principal diagnostic objective is the attempt to discern whether the obviously disturbed child has emotional problems which are fundamental aspects of personality and self-appraisal, or are sequels to sensory, perceptive, or mnemonic deprivation. Many deaf children become so communicatively frustrated by the time they are 3 years old that their emotional disturbance may overshadow the basic problem.

At one extreme of possibilities among emotionally disturbed children is the child with the Straussian syndrome—completely distraught by problems of perception. He simply cannot organize his world through the sensory and perceptive functions at his disposal.

At the other extreme is the schizoid child, whose world is relatively well organized in sensory and perceptive terms, but for whom this does not make any difference. He is away from it, in any sense of the direct relationship of ordinary values. He may carefully step over every toy in the room, while maltreating the instep of every adult present. He may commonly *not* respond to sound, not because he is deaf, but because sound is not an acceptable stimulus for him; he does not want it.

Between these extremes are many combinations and degrees of emotional states and communicative handicaps, resulting in one or another aspect of the deviation from normal reactions called "disturbance." It is important for the clinician not to confuse *lack of response* with *inability to respond*, so far as the sensory systems are concerned.

Speech Disorders

Among the defined speech disorders (exclusive of stuttering, a speech dysrhythmia which is a symptom of an underlying anxiety state) perhaps 70 percent are usually grouped under the rubric "dyslalia" or "functional articulatory disorder" as distinguished from an impediment caused by cleft palate or some other clearly discernible structural inadequacy. Clinical evidence has been growing rapidly (though not experimental evidence) to indicate that many children suffer a natural inability to monitor their own speech output with precision.

The obvious disparities of the lispers and the lallers from normal speech indicate an inadequate kinesthetic development. This too may be a result, however, not a cause, the basic difficulty residing at the sensory-motor level in an inability to remember the details of sound-sequence from the speech of another person. An extreme form of this is a disorder called "cluttering."

The clutterer may share with the stutterer the usual forms of perseverative or retardative dysrhythmia, but far from being burdened with an anxiety state the clutterer does not care what he says. He cannot monitor himself sharply, and simply bumbles along, expecting the world to do the best it can in making sense of his utterances. He is like the trained mule; he can perform well if one can get him to pay attention to the demands of the occasion. The mule may require the ministrations of a club; the child needs speech training by a sergeant major.

At another extreme, an aphasiac child in early infancy may have shown clear auditory orienting reflexes, but later, not being able naturally to learn and remember verbal symbols, may have inhibited the reception of sound, commonly enough all sound, environmental as well as verbal. The young epileptic not infrequently goes through a similar repressive stage. The problem of these children is not that they do not hear. The problem lies at a higher organizational level, an inadequacy in memory for the symbols of sound and a resultant failure in ordinary reflexive responses to sound of any kind. In some respects, it may well be that these children learn "not hearing" as a kind of defense or adaptation to a confusing world.

The Listening Mechanism

This commentary would be incomplete without reference to the organic listening mechanism. Current experimental evidence quite clearly demonstrates the existence of a neural network, including not only afferent fibers but a complex set of efferent fibers which compose a central alerting system for the hearing end organ, the ear. It seems obvious that many of the clinical entities which entail sensory and motor disparities, auditory and otherwise, may involve this alerting system at any point from the cortico-thalamic tracts to the peripheral structures. Children with involvement here need consistently to be alerted to sound and to be taught to attend to it, so that the various complexes of environmental sound may become sources for learning and for normal relationships with the social world.

We have, then, not a simple straightforward picture of hearing in terms of a black-and-white, you-do-or-you-don't kind of behavior. Rather, the various communicative disorders represent some form of breakdown in a sensory-motor continuum. Hearing, language, and speech are not unrelated operations. Naturally, they may be studied as though they were, but the studying does not make them so. On the contrary, in developmental terms, these various aspects of receptive and expressive behavior are inextricably bound together in a kind of feedback loop of relations between the individual and his environment. A child hears, learns to listen, learns language, learns to talk, learns to hear himself, listens to himself in comparison with what others say, and so on. Any serious interference with or breakdown of this self-monitoring loop may profoundly upset its integrity.

Because of the nature of common causes and effects, a large proportion of atypical children have real difficulties in hearing, in learning language, or in speaking. A historical label—the deaf child, the child with delayed speech, the retarded child, and so on—does little justice to the complex of the communicative disorder, or to the effect on "the whole child." The point is not that some deficit in a child is primary and another secondary, but that there is communicative confusion in the way the child can relate to his world. The various confusions in this regard require insightful recognition and handling, not as entities but as part of the total picture of the child with multiple problems.

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[1] Baker, Herbert Koepp: Cleft palate habilitation—present tense. *Children*, May–June 1955.

Through eight years of experimentation North Carolina is finding ways of . . .

SURMOUNTING THE HURDLES TO HOMEMAKER SERVICES

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AFTER SEVERAL years of experimentation, the North Carolina Board of Public Welfare believes it has found a way of encouraging the development of homemaker service to children in both urban and rural areas.

Of all the services which have been established to benefit children, homemaker service has been among the slowest to grow. It seems paradoxical that today when child-welfare workers are convinced of the importance of keeping children in their own homes and of strengthening family life, they have such a difficult time in building up a program which has these two goals.

The recent directory of homemaker services compiled by the U. S. Department of Health, Education, and Welfare[1] reveals that the 145 homemaker programs existing in the spring of 1958 were located primarily in the largest cities of the country and were operating primarily under private auspices. It also shows that since 1950 the number of agencies providing some type of homemaker service had more than doubled. This may seem tremendous growth, but there were still 16 States with no programs at all while few States had programs that reached out into rural areas.

In some States where programs have been developed a number of problems discourage expansion. These problems appear to be most acute in small agencies. No one seems to question the value of homemaker service as a tool to keep families together and to strengthen family life. But where does it fall in the list of priorities of service in our child-welfare programs? Usually pretty far down the line.

Why is this? Is a homemaker service a luxury only the wealthier counties and private agencies can afford? Why does it not stir the imagination of public-welfare administrators or community leaders? Is everyone aware of its potentialities? Does it lack professional status? Is it confused with maid service? Have child-welfare workers given sufficient time to its interpretation and if not, why not? Or is there an impediment in staffing? Are good homemakers hard to find? How can child-welfare workers help?

The experience in North Carolina points to some of the answers to these questions.

The History

In 1947, the State Board of Public Welfare using Federal child-welfare services funds initiated a demonstration of homemaker service in three counties, two rural and one urban. Since the State had (and still has) a locally administered, State-supervised public-welfare program, the county departments of public welfare employed and supervised the homemakers though the Federal funds paid for their salaries and travel. The three counties were selected because of their interest in offering the service and because they had other basic services such as a foster-home program already established. In each county two homemakers were taken on as regular employees of the local welfare department with merit-system status. They had suitable office space and were covered by the same personnel practices, except for

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Based on a paper presented at the 1958 Southeast Regional Conference of the American Public Welfare Association.

working hours, as were all the department's other employees.

The original plans for the program are described in a 1948 report of the division of child welfare. Briefly these were:

Qualifications of homemakers. In general the merit system qualifications decided upon included: successful completion of elementary school and 2 years of successful homemaking experience, either in own home or in a paid capacity; good physical condition; ability and personality to work with children and parents; good judgment, tact, resourcefulness in meeting situations and problems in the home; ability to make flexible adjustments; and good moral character; all this to be determined through interviews, physical examination, and references' statements.

Compensation and hours of work. Since the homemakers might be used for day care or for 24-hour service, it was necessary to establish work hours and a compensatory pay plan. The work week was set at 39 hours, the same as for other local staff members. Any time over 48 hours of work a week put in by a homemaker not serving on a 24-hour basis was compensated for by allowing an equivalent amount of time off. If the homemaker was employed on a 24-hour basis, she was to be paid one and one-half times the base salary and to be given a minimum of one-half day off per week.

Each county was to set a salary in line with the existing wage scale in the respective counties, to be approved by the State Board of Public Welfare. Provision was made for meeting expenses of transportation to and from assignments and for reimbursing the homemaker for other expenses by means of an expense and subsistence allowance. Like other workers, the homemaker was expected to pay expenses of transportation to the agency to report for work.

Two items of expense were made the responsibility of the county during the project. One was the provision of office space, supplies, and equipment needed to carry on homemaker services and the other was to meet needs of families requiring other assistance for the homemaker's service to be of any avail.

Types of situations. Homemaker services were to be provided to families on a temporary basis in the following situations: (1) when the mother was ill, had deserted, or had died; (2) when the mother's temporary absence from home for some other reason was resulting in neglect of the children; (3) when a foster mother was ill; (4) when there was otherwise a temporary need for special care in a family in order to prevent neglect of the children. Temporary care was defined as service for one month or less and in exceptional cases might be extended to 3 months.

Eligibility for service. Services would be available to clients of the agency, any person applying to the county welfare department for homemaker service automatically becoming a client upon determination of his eligibility for the service. In order to keep the project as simple as possible, it was decided that the local departments of public welfare could not allow other agencies to purchase the service.

Determination of eligibility was to be based on the inability of the applicant to meet 100 percent of the agency's public-assistance budget for aid to dependent children. This was the same as the method used to determine medical indigence. The services were to be available to families of any size. Selection of families to be provided homemaker services was the responsibility of the caseworker and his supervisor, with the approval of the local administrator.

Role of the homemaker. The function and role of the homemaker as an integral part of the social agency's service was a basic feature of the project. Manual material carefully set out a plan for the social-service aspects of homemaker service. The role of the caseworker in helping families using homemaker service was recognized as an important factor in determining its effectiveness. At all times the caseworker was to give continuing casework supervision to the families participating in the project.

The definite principle was established that homemaker service was to be used as an alternative for foster care. It was not then planned for use as a teaching program for families needing help in regard to budgeting, meal planning, marketing, and housekeeping. It was expected, however, that in many instances the homemakers would have an opportunity to stabilize a home and strengthen the family ties by training children within the home. It was stressed that all plans involved the cooperation of the responsible adult in the family group and his or her full acceptance of any changes that might be suggested.

In no instances was the homemaker used without the full cooperation of the parent or parents. The service was not superimposed but was used only when the parent or parents wanted to maintain their home and when the use of a homemaker meant a constructive plan for keeping the family together.

Considerable time was needed for planning the homemakers' assignments, particularly in regard to transportation, meals, and especially work hours. In order to be in school many rural children leave home early in the morning. Since family life in a rural community cannot be geared to a 9 a. m. to 5:30 p. m. work day, it was necessary in making the homemakers' schedules to consider at what period of the day their presence is more important to the health and welfare of a child. In some isolated sections the homemaker had to use taxicabs, which were expensive. In most instances it was necessary for the agency to provide a meal allowance for the homemaker in budgeting for the family since in all cases the families were living on marginal incomes or public-assistance grants. The homemakers' ingenuity and ability to adjust to new situations, and the caseworker's support and skill in working with her were necessary to the effectiveness of the projects.

Evaluation of demonstration. Many of the problems which arose were due to the fact that demands upon the time of persons responsible for the projects limited the amount of interpretation and supervision they could give to the program in its first months. In some instances the need for these services reduced the homemaker's effectiveness. In the rural counties the problems of travel presented difficulties, but they were not insurmountable. In some instances cases selected for homemaker service involved difficult social problems which tended to complicate areas of responsibility. This would probably be true in any agency which has a backlog of families with problems which might lead to longtime care.

After Eight Years

The demonstration showed that homemaker service is of immeasurable value to children in sparing them the trauma of separation from their homes and their families. This is without question its greatest contribution in a program for children. But the project also revealed a way of saving dollars and cents, since the salary of a homemaker proved to be less costly for the average family receiving the service than either an aid-to-dependent-children allowance or foster-home care would have been. This was true because most of the families helped had four or more children. It would not have been true with small family groups. However, not many small families had applied for such help.

"Homemaker" became a permanent, classified position under the merit system. Federal child-welfare-services funds were used to reimburse counties for homemakers' salaries as for all other approved child-welfare positions—100 percent of salary for the first year, 85 percent for the second year, and 65 percent for the third year and thereafter.

At the conclusion of the demonstration in the three counties, only one, the urban county, retained the program. With relatively small administration budgets and staffs, the other two counties found their share of the cost of two homemakers too high in relation to other staffing needs. Two more urban counties initiated a homemaker service shortly thereafter. Thus three urban counties were providing the service in 1955 when the North Carolina State Board of Public Welfare reviewed the programs in detail.

Some of the original difficulties still existed, some new ones had developed, but many had been solved. The county agencies themselves made many suggestions for improving the service. The three counties with homemakers reported their intention of continuing the service because of its value but did not know what to do with homemakers "between jobs." In one county the homemakers were allowed to remain at home during such intervals although the administrator doubted whether this was fair to other staff members. In another county, the homemakers filed correspondence and repaired used clothing, and in the third county the homemakers made clothes.

Here obviously was a serious problem. Was the answer to pay homemakers on an hourly basis? We looked to Colorado, a rural State, which has had a homemaker program since 1937. Their homemakers were screened and approved much as were foster parents. As cases needing homemaker service arose, the county departments of public welfare applied for use of an approved homemaker and the State welfare department's division of child welfare passed on each application. While this plan had worked well in the early days of the program, during World War II the homemakers accepted full-time, regular employment elsewhere and continued to do so afterward. Though some few women preferred employment on a case-by-case assignment, most preferred steady work. Colorado, we found, was about to change to North Carolina's plan.[2]

This confirmed our opinion that we were on the right path so we looked at the homemaker program again. Could we broaden the responsibilities of the homemaker to include service not only to families in which the mother or foster mother was out of the home or incapacitated, but also to families in which the homemaker could teach inadequate parents how to give their children better care? This type of service had been specifically excluded from the original list of the homemakers' responsibilities. After getting the Children's Bureau's approval to use Federal funds in this way the State Board of Public Welfare broadened the definition of homemaker service to include service related specifically to maintaining and raising the standards of a family's home life.

Two other policies were changed. One eliminated the "temporary care" qualification which had restricted service to one month or less or to three months in "exceptional cases." These restrictions had been found to be too limiting. Many mothers were out of the home for longer periods. Moreover, in the new "teaching" aspect of service, mothers often needed help week in and week out for many months. Therefore, the time limits were deleted from the regulations. The other change liberalized the definition of financial eligibility. This was broadened to include applicants who could not meet 100 percent of the budget used to determine eligibility for school health and crippled children's services, a budget substantially higher than the aid-to-dependent-children budget formerly used as a criterion. In this way more families with marginal incomes could be helped.

In a Rural County

Since then three more counties, two of them rural, have added homemakers to their child-welfare staff. In the rural counties because of the small population the numbers of cases with mothers or foster mothers out of the home or incapacitated are very few. In the great proportion of families using homemakers the mothers need help in budgeting, in buying, in learning to mend, to can, to prepare special diets, to bathe infants, and the like.

One of these counties is Bladen County, with an estimated population as of July 1958, of 31,800, the largest town having a population of some 1,700. Between February 1957 and January 1958 the county's two homemakers served a total of 65 families, 51 of whom were receiving aid-to-dependent-children allowances and 14 of whom were receiving no financial assistance. Of these, 11 had been closed and 54 were still active as of January 1, 1958. The length of time the cases were active varied according to need and use of the service.

Following is a summary of the Bladen County service.

The homemaker ordinarily spends from 1 to 4 hours in each home visit. The frequency of the visits vary. Some families require daily visits at the beginning. The visits, however, are usually on a weekly, semimonthly, or monthly schedule. There is no limit to the length of time the homemaker can stay in the home as long as her service can meet the needs of the family.

The homemakers keep day sheets recording their family visits and make notations as to major services rendered. They keep notebooks for their own convenience and for use in conferences. The caseworker makes an entry in her case record of the services given and how the family has used them.

The cases are selected in conference by the caseworker and the superintendent of public welfare, who is also the supervisor. The family is prepared for the service by the caseworker. The homemaker is introduced to the family by the caseworker.

The homemakers have selected parents to be invited to demonstration conferences held by a nutritionist from the State Board of Health, at which the nutritionist talked about food values and demonstrated the preparation of balanced diets from low-cost foods. These conferences were held once a month for a 6-month period from 9 a. m. to 11 a. m. while the children were in school.

Let us look at a typical family, a deserted mother and five children receiving an aid-to-dependent-children grant. At the time the homemaker service was initiated this family had very little clothing or furniture. The children's school-attendance record was poor.

The homemaker has made weekly visits in this home. Through budgeting, planning, and some carpenter work carried out under the homemaker's supervision the family has improved living conditions. Several pieces of used furniture have been purchased. The family standards have improved and the children are now regularly in school.

One child had rickets. The homemaker helped the mother plan the recommended diet for this child who has since fully recovered.

In another family receiving homemaker service both the parents are slow mentally and the mother is also a polio victim. There are three very young children.

The homemaker and child-welfare worker have worked very closely with this family. With help in home management, in how to bathe the babies, in how to budget and buy, the mother has been able to cope with her responsibilities more adequately. The family frictions have lessened and the relationship between the parents has been strengthened.

This was a new approach to the use of homemakers in North Carolina. It is being used to an even greater extent in the new demonstration program the State has recently set up for using homemaker service to help older people.

Now with a greater potential in caseload, it is possible to keep the homemaker busy. There is no longer any period of waiting for a case to turn up. A schedule can be planned and work organized for a week or a month. If an emergency arises which demands priority, as when a mother is hospitalized and no other homemaker is available, the agency notifies a family having a teaching visit scheduled by a homemaker that the visit must be canceled and why. While this plan still presents some problems, the teaching visits may be planned with a kind of flexibility that is helpful in the administration of the service.

About Priorities

This brings us to a crucial point. There must always be enough time for adequate supervision of the program—not only in the beginning as the early report suggested. In large agencies the homemaker staff is generally big enough to be in a unit with at least one full-time supervisor. In small agencies the supervision of the service must be under a person who has other responsibilities. Because of pressures which may seem more immediate—public-assistance reviews, foster-care planning, juvenile-court studies, and other urgent tasks—little time may be saved for the homemaker. This neglect may be traced not only to the supervisor's methods of determining priorities, but also to the priorities which the administrator sets. It raises the question: Have public-welfare administrators given homemaker service the time and thought it needs to be as effective as other more familiar programs?

One fundamental problem in the development of homemaker service is that program planners do not attach the same importance to it as they do to other services. Is this because in the past by using it only in emergency situations, we grew to think of it as an emergency service—a temporary expedient—rather than as another resource for children as basic as, or even more basic than, foster-home care? Or is it that social workers look upon this service as somewhat less than professional because of the responsibilities and qualifications designated as the homemaker's?

It took child-welfare agencies years to accept foster parents as valuable members of the agency team. Child-caring institutions only recently began to recognize the key role that cottage parents play. Hopefully, it will not take long for homemakers to be accepted as members of the team. Hopefully, too, the caseworker can be helped to see that her skills as a social worker do not necessarily include skills in homemaking, that such skills can be provided by a competent homemaker. The caseworker's skill in-

In Wake County, N. C., a homemaker from the county welfare department serves a permanently disabled mother and her three children. Because this homemaker service for children has no time limitation it can be used to help mothers with chronic disabilities to keep their homes together, as well as to help families needing the service only temporarily.

cludes the ability to recognize her client's need for homemaker help and to prepare the client to accept it positively.

Thus it is obvious that a homemaker must have status—status with the agency's clients and with its other workers. She must be regarded as a member of the staff with special skills to contribute to the total agency program. She must serve on appropriate agency committees and must have the opportunity to attend appropriate conferences. And she must have as much opportunity for staff-development programs as have other staff members.

In North Carolina the homemaker now receives compensatory time for overtime, hour for hour, in accordance with agency policies on overtime. The original policy of payment of time and a half under certain circumstances has been discarded so that the same personnel policies and practices apply to her as to other employees.

There is a strong belief in North Carolina that homemakers must be very skillful people, prepared to adapt easily to new situations and new people, resourceful and patient, with ability to help individuals learn some of the principles of good homemaking; and that persons with these skills are entitled to salaries that compensate them adequately. The prevailing wage of a maid will get a maid. A homemaker has greater skills and responsibilities than a maid and must be paid more. The North Carolina salary maximum for a homemaker is $250 per month. None of the homemakers earn that much now, but the State Board of Public Welfare recommends a minimum of $200 and some homemakers are getting more than that plus travel expenses. Homemakers employed in rural areas have their own cars, thus solving the problem of transportation.

As for academic qualifications North Carolina has been most fortunate in securing persons with college backgrounds for some of its homemakers. All are married and have at least some high-school work. Selection, too, can be made with a view toward assuring status.

Training and staff-development programs are directly related to the fact that homemakers are employed by and supervised by staff in the county departments of public welfare. The orientation and inservice training programs have been the responsibility of the counties. However, as a result of a request from supervisors, periodic statewide workshops for homemakers are being planned by the State. We hope to learn from experience how to gear further staff-development planning; but we know now that the homemakers, their supervisors, and administrators want the program and want help in making it more effective.

Budget and Expense

One final point needs emphasis. Adding two homemakers to a small county agency budget looks rather expensive to the county officials who approve budgets and handle the purse strings. While child-welfare-services money carries the greater proportion of the salary, other expenses are involved. Moreover, all too often agencies have not been able to get approval for all the casework staff they need. They ask: "Are we justified in pushing for a homemaker program before we have adequate casework staff? If so, how do we sell it to our boards and county commissioners?"

These are the same questions which I asked almost 20 years ago as I tried to develop a foster-home program. I have learned two fundamentals which hold true regardless of the new program to be developed. First, no agency ever had enough casework staff. Therefore, if an agency waits for that happy day before moving to the new, that agency will never move. Certainly casework staff must have high priority, but too often lack of adequate staff is an excuse for lack of progress. The skillful administrator knows when and how to move. Secondly, an administrator who really believes that a public-welfare agency has a responsibility to help every person in social or economic need can find the courage and the ways to develop new tools with which to help people.

A great deal of information is available describing homemaker services generally. Currently, committees in various parts of the country are developing material to stimulate the establishment of homemaker services in both large and small communities. They are doing this as groundwork for the National Conference on Homemaker Services, to be held in Chicago in February 1959. (See page 36.)

The searching look being given homemaker services during this next year will give us new information and a new emphasis. Both will help as public-welfare programs are advanced to strengthen services to children and their families.

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[1] U. S. Department of Health, Education, and Welfare: Homemaker and related services, 1958; a directory of agencies in the United States. Children's Bureau Publication No. 370. 1958.

[2] Perkins, Juanita V.: The homemaker-service program of the child welfare division of the Colorado State Department of Public Welfare. In the Proceedings of the 1957 National Homemakers Conference (mimeographed). National Committee on Homemaker Services, 1958.

A JOINT-INTERVIEW TECHNIQUE WITH MOTHER AND CHILD

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A TECHNIQUE of holding joint interviews with mother and child has been developed in the Department of Psychiatry, Royal Children's Hospital in Melbourne, Australia.

This development was stimulated by the limitations of the currently available procedures in clinical work with emotionally disturbed children. In outpatient practice these procedures rely mainly on samples of behavior obtained under specific conditions far removed from reality and involving one-to-one relationships between the clinician and the child, supplemented only by verbal reports.

The modification of the conventional practice of seeing the mother and child separately has been aimed, therefore, at improving the validity of the inferential jump from clinical data to real life by observing them together in a natural setting as far as this could be approximated in an outpatient clinic. This experience is reported in the hope that it may stimulate further research and thinking along these lines.

The joint interview with the mother and the child usually takes place in a playroom. The mother, child, and clinician become involved in a reciprocal relationship. During the process, a variety of materials useful for stimulating projective activity is introduced—puppets, clay, paints, or other toys. Generally, both the mother and the child are encouraged to use these materials in their own way. However, in some cases the verbal interview remains the basic tool of communication. Children in the latency period (ages 6–10) and younger have reacted most favorably to such joint activities although the technique has also been effective with some older children.

The technique makes it possible to assess: (1) the mother-child relationship; (2) the mother's functioning; and (3) the child's functioning. Its use necessitates the evaluation of: (1) the role of the clinician; (2) the value and limitations of the technique; and (3) its applicability.

Mother-Child Relationship

The opportunity to observe directly the interaction between the mother and the child enables the clinician to assess more accurately the nature of the mother-child relationship in both its affective and cognitive aspects and in regard to the distribution and degree of control.

The affective aspects can be gauged by noting:

1. Speech behavior—its content, inhibitions, tone of voice.
2. Nonverbal behavior—gestures and other subtle indices of their attitudes toward each other such as their spontaneous seating arrangement.
3. Areas of conflict and of harmony. For example, a mother may tolerate her child's masturbation but become angry when she sees him spill some paint on his jacket.
4. The degree of consistency in emotional reactions. This is particularly important to note as it can give clues to the interaction between the pathology of the mother and that of the child and to the child's response to shifts in maternal affect. For example, a mother who is subject to depression may accept

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her son's playful expression of aggression when she is feeling well, but react with intense hostility to identical behavior occurring while she is in one of her depressed moods. The same boy may display much more warmth when his mother feels well, but become withdrawn or aggressive in response to her depression and hostility.

In such affective interplay, both its conscious and unconscious elements become immediately apparent. For instance, a mother may turn to a child and say: "Go on, say something. Doesn't mother always tell you she loves you?" In remarks such as this, which are not uncommon, the denial of hostility, ambivalence, and the depth of feeling or its various substitutes can be witnessed directly in the form in which they operate on the child.

In a joint interview, it is also possible to detect quickly the presence of an unconscious affective link described by Adelaide Johnson through which the mother derives vicarious gratification from the child's unacceptable behavior.[1] The mother may laugh while she is scolding the child for wanting to take a toy from the playroom or she may try to explain away the child's behavior. The seductive elements in an otherwise hostile mother-child relationship are unmistakably revealed when a mother shrieks with excitement: "Don't peek! Don't peek!" as her son tries to see what she is painting, thereby encouraging him to do so and working him up into a similar state of excitement.

The *cognitive aspects* of the mother-child relationship may be inferred from both the overt and covert communication between the mother and child. A breakdown in *overt communication* between the two is one of the most common "symptoms" of an awry relationship seen in the clinical population. These two people live together and are involved in one of the most intimate relationships provided by society, yet tragically they often face each other like perfect strangers.

The joint interview dramatically exposes the limited and frequently distorted perceptions mother and child have of each other. In fact, in some instances, the protective presence of the clinician presents them with the first opportunity they have had to face each other squarely and to realize what they feel and how they influence each other's behavior. In less severe cases an experience of perceptual correction, thus achieved, removes the previous block in communication and may be all that is necessary to free mother and child for a healthier interaction through which they can work out their own solutions to the problems for which the mother sought help.

The Australian experiment described here is one of a number of efforts today to bring reality into the process of treating emotional problems. In the United States departures from exclusive reliance on scheduled one-to-one interviews are most frequent in the forms of group therapy or counseling in which the interactions within a group of selected patients, or clients, are made tools of the treatment process. Some experimentation in simultaneously interviewing several members of the same family is also taking place in a few agencies practicing family-centered casework wherein the family as a whole is regarded as in need of treatment.

In another direction, but with a similar recognition of the strength of life as it is being lived in determining the outcome of treatment, are the on-the-spot treatment techniques being developed in small residential-treatment centers for extremely aggressive children, as at the experimental home at the National Institute of Mental Health, Bethesda, Md. There children are seen by a psychiatrist not only in scheduled interview sessions but immediately on the scene of action when and where an emotional explosion occurs.

In all cases except those in which the child's pathology precludes verbal communication, such an experience provides an important first step in clearing the ground for a new relationship. Hearing her 7-year-old son tell about how worried he is about her staying up late and smoking continuously and of his desire to help her may come as a revelation to a hostile, relentless mother. Hearing his mother brag about his mechanical abilities may be no less of a revelation to a child who has experienced nothing but nagging and criticism at home.

In the process of carrying on various activities together, both mother and child expose numerous facets of their relationship, not only to the clinician but to themselves as well. For example, when a child invites his mother to join him in his play she may suddenly realize that she has never given him enough time at home. Or, watching the clinician's calm acceptance of the child's spontaneity or his messiness, a mother may for a moment become an impartial observer and perceive these activities in a new perspective.

Not uncommonly in a joint session, a mother may become aware of assets and positive qualities in her child which she did not see before. For example, a girl who has previously functioned poorly in every way may in this supportive atmosphere produce "works of art" in clay or painting and thus deal the first blow to her mother's conception of her as a "good-for-nothing." Similarly, seeing a child she has regarded as having "no heart and no sense of shame" blush unhappily while the clinician is told of the child's misbehavior forces the mother to reevaluate her previous conceptions. Needless to say, the experience of sharing and enjoying an activity with his mother also alters a child's perception of her by showing him her interest and willingness to give of herself.

Covert communication, the subtle type of communication which often creates marital difficulties, when spouses unconsciously respond to each other's pathological needs, also plays an important role in mother-child pathology. The way in which mother and child are aware of each other's unconscious needs is at times almost uncanny, although a thorough investigation would probably reveal observable perceptual processes at work.

The joint interview makes it possible to detect such psychological "dovetailing" and to assess its extent, degree, and temporal relationships. Much can be expressed through the projective medium of clay or paint or any other plastic material. From the ways in which mother and child use such materials simultaneously, insight can be gained into their fantasies and interaction. The playroom may be set up in a way to prevent the mother and child from seeing each other's productions while painting. Yet a later comparison of their work often reveals a subtle interplay between the two, the child's and the mother's fantasies mirroring or complementing one another.

The nature of the *control system* in the mother-child relationship can be observed as the mother and child handle the many different situations arising in the course of their joint session. The distribution of power, the methods used by each to gain or reinforce control, and the quality and degree of self-control in their dealing with one another become immediately apparent.

In the joint interview the clinician can easily distinguish insecurity or impulsivity from positive firmness in a mother no matter how hard she tries to "put up an appearance." No mother playing a studied role of a "good mother" could fail to reveal herself when faced with the kind of behavior on the part of her child which brought her to the clinic in the first place and which is very likely to show up at one time or another during the session.

"There will be no movies tonight so you better forget about it." With remarks like this to her child the mother gives better information about her method of handling him than reports on her disciplinary measures. They also help the clinician to assess directly the appropriateness of the controls to the child's age and abilities. Similarly, a mother's expectations for her child are demonstrated as she puts a coat on a physically normal 10-year-old girl or commands an active, spontaneous 5-year-old boy to "behave like a man." The clinician's handling of the child provides the mother with a model of alternative, more effective techniques of control. This can be much more meaningful and convincing to a mother than theoretical discussions with a worker who always sees her alone and has had no experience with the child.

While the affective, cognitive, and control aspects of a mother-child relationship have been discussed here separately, in practice they constantly interact as do diagnosis and therapy.

The Mother

The mother's initial perception of the clinician and his role depends, of course, on the basis of her referral. If the school or other external pressures are responsible for her visit, she can be expected to regard him as a threatening authority figure. If she is seeking help on her own initiative she is likely to invest him with more positive, benign authority.

In either case her feelings are mixed, but the original orientation always shows up in the first session, exposing in some ways how she relates to authority figures, and thereby throwing important light on some aspects of her own personality. These may show up directly in her interaction with the clinician, but in the joint interview she also reveals them indirectly through the child.

For example, a mother may invoke the clinician's authority every time she tries to reinforce her own order to her child. She may say: "Sit still—he wants you to listen," thereby betraying her own dependency and helplessness. Or she may reveal even more severe infantilism by unconditionally turning over her authority to the clinician. At the other extreme, a mother may see herself in a power struggle with the clinician and may attack him verbally or take over direction of the session by manipulating the child.

Whatever the mother's motives in bringing the child to the clinic, her act of doing so represents an admission of her own inadequacy in managing him. This means that one aspect of the clinician's role in the mother's eyes is that of a judge who has the power to pronounce the verdict of "guilty" or "not guilty." To have her handling of her child openly exposed to another's scrutiny is distressing to any mother. Her response to this stress, the ease with which she can recover from it and adapt to the clinical situation, and the changes in her behavior as she feels more comfortable are valuable diagnostic indices of her own functioning.

The way a mother handles a projective activity, such as painting or play, also provides extremely useful clues as to various aspects of her personality structure and pathology. In our experience none of the mothers have ever refused to participate in such activity. It seems that in our overcivilized culture which offers adults few outlets for fantasy expression, the freedom for self-expression is basically gratifying. However, the provision of this opportunity in a clinical setting usually mobilizes some ego defenses. Therefore, the analysis of these defenses or their apparent absence can throw some further light on the mother's ego strength. With this in mind, it is profitable for the clinician to attempt to differentiate three aspects of the mother's projective activity: (1) its focus; (2) its content; (3) its form and level of organization.

The ease and rapidity with which a mother accepts an activity is usually significantly related to the *focus* she gives it. Some mothers regard the projective activity as part of a total program designed to help the child. They ally themselves with the clinician and even though they may enjoy the activity, they take part in it mainly for the sake of the child. In other words, although they momentarily regress to the child's level, they do so intentionally, as adults. On the other hand, a narcissistic mother uses the activity for her own ends and for her personal gratification. She seizes the opportunity to be a child once more and to interact with her own child on this level.

An important clue to the focus the mother has given to the activity is provided by the psychological distance of the *content*. This could range from emotionally peripheral to central issues as the mother's productions vary from impersonal to conventional or symbolic themes. In some cases they may openly express her problems, feelings, and mood. Such expressions reveal information about the mother's own needs and areas of personal conflict and have to be handled with extreme caution.

Form and organization of the content of the mother's activity, when analyzed along conventional lines, provide additional information about the nature of her control system and about her emotional and intellectual development.

Where feasible, the mother and the child are encouraged to talk freely about their associations with the nonverbal projections. What they say is then subjected to similar analysis by the clinician.

The Child

The child, in sharing the clinical session with his mother, reveals his physical and intellectual resources, skills, and deficiencies much as he does in an individual session through verbal interaction or projective activity or both. Either type of session provides the clinician with an opportunity to evaluate to some extent a child's capacity to relate to others and to accept limits. However, basic differences exist in what the joint interview reveals about other aspects of the child's emotional functioning.

At the very early stage of a contact, the mother's presence may give the child a sense of purpose and security but also limits his freedom. His hostility to her may inhibit his spontaneity while his dependence on her may make it difficult for him to behave in a way he knows would intensify her rejection of him. These inhibiting factors have both advantages and limitations from the clinician's point of view.

The way in which the child handles his hostility to his mother in the session indicates the quality and intensity of his ego strength and controls. From the demands he is making on her we can directly assess the nature and intensity of his emotional needs and the way in which he tries to gratify them. By comparing his reactions to the mother and to the clinician, the clinician can gauge the child's repertoire of feelings and their depth as well as his defenses.

However, in some cases, particularly of neurotic children, the more primitive layers of a child's personality may not show up at all. If they do, they usually appear as fantasy, for in a joint interview a neurotic child rarely relinquishes behavioral controls to the extent that he sometimes does in an individual session.

Thus, while the joint interview may be an invitation to regression for the mother, it may have the opposite effect on the child. The clinician has to be aware of this in order not to overestimate the level of the child's emotional development.

Clinician

In classical child-guidance practice the clinician commonly sees the child and the mother one at a time. In group therapy he becomes involved in multiple simultaneous relationships, but the membership of the group consists of people who are not intimately related to each other and are more or less alike in age, mental development, patient status, and other important variables. In marriage counseling, and even in joint interviews with both parents, the participants do have close personal ties but they too are of more or less equal status.[2] But in joint sessions with mother and child, the clinician is dealing with two people who are not only intimately related to each other but are at widely different stages of development. Their role relationship is that of an authority and a subordinate who is physically, emotionally, and socially dependent on this authority. Their clinical status differs in that the child is the patient while the mother is not.

These important differences contribute to the complexity of the joint interview, which imposes much greater demands on the clinician and his skills than other types of therapy. Above all, it calls for considerable flexibility and the capacity to function simultaneously at different levels without personal discomfort and to assume many different roles in the course of a single session. It also requires the clinician to have come to grips with his own problems in relation to parental figures, as the joint mother-child interview more than any other clinical procedure offers opportunity for countertransference and one-sided identification with parent or child.

While the clinician avoids such identification at times he allies himself temporarily with the healthier aspects of the mother or the child whenever these come to the fore and attempts to strengthen them. On the other hand, the clinician accepts the acting out of hostilities within therapeutically beneficial limits.

The balance between withdrawal and participation on the part of the clinician has to be carefully gauged in order to prevent a mother from regressing further than would be safe for her parental status, or to avoid creating anxieties in the mother by seeming to take over her function. The clinician is dealing here with an important reality relationship which must not be undermined.

While a mother may develop an attachment, or transference relationship, to the clinician, so far a mother's hostility, or negative transference, has not presented serious problems. The possibility of this occurring, however, deserves a fuller scrutiny, for it could in practice create a most difficult and undesirable situation.

At this stage only two tentative explanations can be offered for the failure of this difficulty to appear:

1. To the relatively more mature mother, who focuses on the child rather than on herself, the clinician may represent the "good object," a helpful ally toward whom positive feelings are directed. Such mothers not uncommonly direct their negative feelings toward some "bad object"—an authority outside of the interview situation, such as a previous doctor who "did not know" or "did not help."

2. In the case of a more narcissistic, immature mother, who regresses for her own sake, the projective activity may absorb some of the negative transference as it often does in individual therapy with a child in the 6- to 10-year age group.[3] However, if this becomes prominent the joint interview has to be discontinued.

The child's transference relationships depend, of course, on his age, the stage of his ego development, and the presence and strength of repression. However, in a joint session he has an opportunity of working through his problems "at the source" in direct interaction with his mother.

Actually, the child's positive feelings for the clinician create the greatest technical difficulties. While these feelings must be preserved, at least during the first stage of the contact, they invariably arouse the mother's jealousy and so create a hazard to the therapy's success. The child never fails to make a dramatic display of his preference for the clinician. Few mothers would not be hurt by seeing their child offering candy or a special gift to the clinician but not to themselves. To overcome this hurdle, the mothers are now warned of this impending development, its meaning and importance are explained, and they are reassured of its transience.

In the course of the contact the strong positive attachment to the clinician is gradually partly transferred to the mother and partly dissipated as the child matures and becomes less dependent. Negative behavior on the part of the child is usually directly or indirectly aimed at the mother. When the behavior is dealt with by the clinician as it occurs, the underlying feelings can be related to its rightful object and then resolved. Symptoms of hostility gradually decrease in frequency and intensity and become much more appropriate.

How one carries out the clinician's role in a joint interview depends on whether the primary concern is with diagnosis or treatment. The specific aim determines whether the clinician fully interacts with the mother or child or reduces his participation to a minimum by withdrawing into the background while they are painting, making comments, and perhaps arguing with each other. The clinician may intervene to clarify, reflect, and at times to interpret to the mother and child their feelings for one another as expressed through their words or actions.

Spoken emphasis is given to any evidence of positive movement on either side. At times it may be advisable to become directive in a nonauthoritarian manner by encouraging the mother or the child or both to express their feelings, to make use of the projective activity, or to seek a solution to a particular problem which has become apparent to both of them in the course of the session. Constructive suggestions may even be offered but always in a way which leaves no doubt as to their freedom to refuse them. In appropriate instances the child's regressive needs are recognized by assuring both him and his mother that it is all right for him to have as many cookies as he likes or to get dirty during the session. On the other hand, the mother may be given support by explaining to the child the realistic nature of her limit-setting.

On rare occasions it becomes necessary to assume an authoritarian role for the sake of psychological safety—as when the child or the mother is about to reveal inner feelings from which the other should be protected. In such instances, an alternative subject or activity may be introduced or steps taken for dealing with these feelings outside of the joint session. The use of humor is often effective when the mother and child reach a deadlock or when the tension between them reaches a dangerously high level.

The clinician must constantly be aware of being pushed into playing a role in which the mother and child want to cast him. Often they try to turn him into a judge by reporting to him each other's misdeeds, and expecting him to censure the guilty party. This can be bypassed by turning such reports into a discussion in which both are encouraged to describe the deplored event, their motives, and feelings about it. Thus they may be helped to gain a better understanding of each other.

Since this description was written the author's attention has been drawn to a paper by John Bowlby which reports the use of a joint-interview technique at the Tavistock Clinic in London.[5]

Value and Limitations

In a sense, the joint-interview approach is not new. It has been used with the preschool child [4] but it still has to be developed into a systematic clinical procedure with older-age children.

This technique provides a way of setting up a miniature "natural experiment" in which by deliberately manipulating the three main variables—the role of the clinician, the verbal versus nonverbal content of the session, and the nature of the projective activity—the clinician can multiply the conditions under which the mother, the child, and their interaction can be observed. It gives the clinician more freedom than is possible in an individual interview to vary his distance from the phenomena studied and to control the degree of his psychological participation. Although his very presence makes it impossible for him to escape influencing the situation, the validity of his observations is improved.

Diagnostically the joint interview has the advantage of being comprehensive. It provides simultaneous information about mother and child with little additional time investment. It allows for relatively quick and reliable identification of reactive elements or the degree of personal pathology in the child's disturbance. By making possible an assessment of the individual areas of strength in the mother and child, their limitations, their readiness, and their capacity for change, it provides a basis for prognosis and treatment planning.

As a treatment method the joint interview facilitates what Madeleine Rambert calls "the conscious realization" of conflicts, bringing the child "face to face with the problem he has previously been unable to resolve in order to give him a more satisfying solution to it." [3] It also helps the mother to achieve this in relation to the child. In the safety of the therapeutic hour, sometimes through make-believe, the mother and the child can reveal conflicts to each other which would otherwise be unacceptable.

For both mother and child the experience of joint sessions can be an extremely gratifying process of reeducation achieved through learning together to understand, to appreciate, and to live with one another. They do this as they interact with the clinician and with each other in the clinician's presence, secure in receiving his help in surmounting whatever hurdles block their communication. The fact that the mother participates in the child's treatment and becomes an integral part of it makes it much more meaningful to her. The shared experience brings mother and child together, increases their responsibility toward each other, and becomes a unifying influence outside of the therapy hour. Routine reviews of some of the cases treated in this way have indicated that even after 2 years the gains made during therapy were maintained in regard both to the mother-child relationship and to the child's personal development.

The potentialities of this technique for research are manifold. The procedure has many dimensions lending themselves to scaling. An objective scoring system would make it possible to investigate: (1) the basic differences in mother-child relationships in various clinical groups; (2) the relationship between the mothers' and the children's pathology; (3) the basic differences between the mother-child relationship in normal children at different age levels for the different sexes, and among different social and ethnic groups.

The procedure could also be adopted to study father-child or sibling interactions.

There seem to be no contraindications for the inclusion of this technique in diagnosis.

In treatment its main goal is to help the mother and child gain insight into their own impulses and needs through an improved understanding of their interaction and to learn to develop the controls and skills necessary for healthy personal and interpersonal functioning. Accordingly, the effectiveness of the treatment depends on careful case selection. For this, the following preliminary criteria are useful:

1. The mother should be reasonably intelligent.
2. The mother must possess enough ego-integration to be able to allow the focus of treatment to be on the child and not on herself. Any mother with serious pathology requiring psychiatric help in her own right must be excluded, for the child could be further traumatized by evidence of her disturbance.
3. No matter how intense the conflict some positive ties between the mother and the child must be present at the outset.
4. Severely disturbed children, whose egos have to be pieced together before reality relationships can be handled, must be excluded.

Place in Clinical Practice

The joint-interview technique is not suggested as a substitute for but as a useful adjunct to conventional diagnostic procedures.

In therapy this technique can be used alone or in combination with other approaches, depending on the nature of the problem. In some cases it can be used as the first stage of treatment during which intense surface hostility and tension between the mother and the child are worked through, affording immediate relief in their interpersonal relationship. It can then be followed by individual sessions with the same therapist. In other cases, where the joint interview remains the approach of choice, it may be necessary to see the mother additionally in an individual interview from time to time, especially if she needs to discuss problems peripheral to the focus of the joint session or if current developments in the session indicate the need for private discussion.

It is not always possible to decide *a priori* on the best course of action. This has to be evolved as the therapy progresses. If the therapist is sufficiently alert, sensitive, and flexible such adjustments should not present serious difficulties.

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[3] Rambert, Madeleine L.: Children in conflict. Trans. by Yvette Moxley. International Universities Press, New York, 1949.

[4] Schwarz, Hedy: The mother in the consulting room: Notes on the psychoanalytic treatment of two young children. *In* The psychoanalytic study of the child, Vol. V. International Universities Press, New York, 1950.

[5] Bowlby, John: The study and reduction of group tensions in the family. *Human Relations*, April 1949.

It has been observed that the movements of the heavenly bodies since the beginning of time are not as complicated as the play of a child for a single hour.

D. A. Worcester in Exceptional Children, *September 1958.*

A case story of the growth of modern child-welfare concepts within an agency and a community.

FROM BOYS' RANCH TO CHILDREN'S SERVICES

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INTENSIVE evaluation during the past 6 years by a children's institution in Harlingen, Tex., has led to the transformation not only of the institution but also of the community's conception of its children's needs. Beginning with a proposal for a fund-raising drive to enlarge the Valley Boys' Ranch, the combined study-action efforts of board, staff, and other members of the community resulted in the conversion of the "ranch" into a multiservice agency called the Valley Children's Services, serving both boys and girls through group care in small group homes, foster-family care, adoptive placements, and casework to parents.

Currently under consideration and study by the board of directors is a proposal to offer financial assistance in selected cases when it is economically sound and in the best interest of the children and family. The board is also considering the provision of homemaker service and marital counseling. The changes have come rather fast during the past 6 years, but slowly enough to be sound. The addition of these other services will necessarily come only after the present program is stabilized and the agency has sufficient casework staff, quantitatively and qualitatively, to handle them.

A full understanding of this development requires a brief review of the agency's 12-year history. It is perhaps fortunate that the agency is no older and was only 7 years old when a new executive director came in 1951. Tradition was therefore not a strong impediment to progress, although the board members' knowledge of practices in some older institutions occasionally stood in the way.

The agency was organized and chartered as Valley Boys' Ranch in December of 1945 to care for dependent and neglected boys. The idea for such a home originated in a local service club, through the instigation of a fund raiser who had helped to establish similar institutions over the State and offered to raise money for the purpose. His offer was accepted and a substantial sum of money was raised over a period of several months. A small house and 50 acres of land—untillable and full of gullies—were obtained just outside the city limits as a beginning.

Everything looked fine until the "help" settled up. The fund raiser had asked very little, it was thought, for his services—10 percent plus his expenses. However, when everything was tallied and his expenses plus 10 percent were taken out, little was left besides the house and grounds. There was not even enough money for the first year of operation. As a result the board members, with no knowledge of what is involved in operating a children's institution, assumed the actual operation of the agency, even to the point of taking turns living with the children.

In 1949 the institution was closed because of inadequate financing. The club which had been the original sponsor enlisted the aid of another service club, which in turn accepted sponsorship on a cooperative basis with all clubs of the same affiliation in a three-county area of the lower Rio Grande Valley—all within a 50-mile radius of Harlingen. With the aid of the entire Valley, the land at the ranch was leveled and underground irrigation was installed. In addition, a barracks building was obtained from army surplus, moved on to the grounds, and completely remodeled by members of local labor unions and others. Materials and labor were all donated for the project, with hundreds of persons participating.

The board changed its membership when the new club took over, but not its function. For 6 more years it directly ran the agency, plagued always with rapid staff changes. Eventually the board decided to hire an experienced executive and to turn the operation of the agency over to him.

Important changes in board organization took place shortly after this. Originally each of the approximately 20 service clubs involved in sponsorship held two positions which were routine appointments with terms of one year each. One problem loomed immediately—it was possible to have a completely new board each year. Usually less than half the members were reappointed for another year, and many persons appointed to membership were not interested and did not attend meetings. Membership was confined to members of the service clubs.

Now board membership is open to men and women outside the service clubs and is the result of election by the board, rather than of appointment. Each sponsoring club is given an opportunity to submit names to a nominating committee, and one member from each club is usually elected to the board. Terms of office have been changed to 3 years, with one-third of the membership retiring each year. A member must be dropped for at least a year after serving two consecutive terms. Any board member who misses three consecutive meetings is automatically dropped. The board is widely representative of the occupations and the communities of the Rio Grande Valley. Nominees for membership are chosen on the basis of proven interest in work for young people, with consideration being given to occupational and geographical representation. Strong committees are now in operation and take an active part in policy setting, agency interpretation, and advising on agency problems.

Beginnings of Change

The change in the philosophy and program of the institution accompanied the change in the board structure and function. Back in 1952 and 1953, the board thought of the institution as providing permanent care for children and "the more the merrier!" In line with the Texan notion of "the bigger the better," a proposal was made to increase the facility to accommodate 1,000 boys, which somehow was to help the agency out of its financial difficulty. Numerous other proposals—including one for the boys to sell popcorn and peanuts on the street corners on Saturdays, with placards on their backs—revealed the complete lack of understanding of child-welfare concepts on the part of many board members and other influential members of the community.

After the arrival of the new executive it took about 6 months for the board and staff to reorganize and stabilize its program. In the light of the recommendations to increase the size of the institution, the staff, with the board's help, attempted, through an evaluation of agency potential and community need, to find out what type of child the agency could serve best. What they found were decided differences between *the child most people in the community thought should have institutional care, the child the agency seemed best able to care for, and the child who actually needed group care.*

The next step in determining which way the agency should move and in bringing the community along with it was a series of meetings attended by the executive and board of the agency, two district and juvenile judges, the supervisors of the county child-welfare units, the county probation officers, the area supervisor for the child-welfare division of the Texas department of public welfare, and the executives and representatives from the boards of directors of other local welfare agencies. The group agreed, on the basis of an actual count of boys known to them, on the need for a facility to care for 500 boys. In planning for action the figure was cut in half, a citizens' committee was formed, and preliminary plans were drawn for buildings. At this time, the average length of stay at Valley Boys' Ranch was approximately 5 years.

When the cost of achieving even this reduced plan became obvious, more doubt was raised regarding the need for such a large plant and for the kind of care the agency would be able to provide. The board, with staff leadership, then took a closer look at "the child who actually needs group care" rather than the one it was felt the institution could best serve. This resulted in the decision to change the agency's function and to improve services rather than to build buildings.

At that time what casework service was being given to the ranch boys and their families was being provided on a hit-or-miss basis by the county child-welfare units, which did not have adequate staff to do their own emergency work, let alone to work closely with the institution's children. After approximately a year of staff interpretation to the board of the need for casework services, the agency hired its own caseworker and initiated a social-services department. In this interpretation, case examples were used to explain how the constant change in caseworkers was damaging some of the children and increasing the length of their stay at the institution, and how, on the other hand, in some instances good casework was helping youngsters and decreasing their length of stay.

The staff also made a thorough study of the kinds of children the agency was accepting, the basis of accepting them, and the kind of planning that was being done for them. This brought about another review of all policies, resulting in changes in those regarding admission and discharge. As a result of these studies and interpretation, the board and the community began to recognize the difference in modern concepts of institutions and the children they can serve as compared with those of yesteryear.

Along with these studies the agency worked with other agencies to reach a clearer agreement about the kinds of children needing group care so that only such children would be referred and accepted for institutional placement. Psychological tests, complete physical examinations, and social histories, along with staff conferences with the caseworkers of referring agencies and with the children's parents, were made requirements for admission. All of these requirements helped in better planning for the children prior to their acceptance, provided the staff with a better understanding of each child, and generally put the agency on a more professional basis. Consultation with a local psychiatrist was eventually made available—a service which is presently being expanded.

In interpreting needs and services to the community the agency involved all of the other welfare agencies. This was necessary in order to develop an understanding of the function and responsibility of each agency in planning for the child, as well as in pointing out gaps in needed services. In these efforts some very effective help came from yearly licensing studies and evaluations being conducted by the child-welfare division of the State welfare department, which culminated in a study by the Child Welfare League of America. Each of these studies pointed out the institution's weaknesses as well as its strengths and helped sharpen the focus on the areas needing improvement. Responsible members of the community, drawn into the evaluations and well informed on the results, took pride in the institution's strengths, learned of changing needs in group care for children, and felt responsible for helping to improve the program.

The increase in the institution's services instead of in its housing facilities immediately began to show manifold results. After being licensed to do adoption and foster-home placements, the agency gradually became a multiservice agency, placing some of its children whose needs could best be met by family living into foster-family homes and some for adoption. The question of whether older children want and need adoptive parents or whether good adoptive couples can be found for older children has been answered by the fact that all adoptions achieved through the agency to date have been of boys 13 years of age or older.

The turnover of children in group care has drastically changed over the years, primarily as a result of increased services. The average stay has fallen from 5 years to 1 year. Therefore, without any additional buildings, the institution is serving more children than it did before the increase in services. Many of the children who previously would have come into the instiution either are being helped at home or in some cases are in foster-family care. Children at the institution who can no longer benefit from group living are being placed in foster or adoptive homes or, in most cases, are returning to their own homes as a result of closer work with parents. As these benefits became more obvious to the board and to the community, the results were closer and better community cooperation and increased interest.

Girls, Too

After a year of operation with the increased services, the agency could show that it was providing better services to children at less cost per child. This was an effective point against the expansion of group-care capacity when the question again arose, as it did at this time. Another series of meetings was held including essentially the same people who attended the series 2 years before—the juvenile judges, chief probation officers, child-welfare-unit director, child-welfare area supervisor, directors and board members of community welfare agencies dealing with children, and other interested citizens. The group looked at the service being provided in the light of community needs, with an obvious change in its basic philosophy regarding group care. It concluded that additional provision for group care was needed not for boys but rather for girls, for whom no facility existed. Since the key to effective change had been community understanding of program and purpose, the agency decided to plan with the community for the creation of such facilities.

Accordingly, a meeting was called early in 1956 at the city hall in Harlingen, which is at the center of the Rio Grande Valley. The meeting was open to anyone who wished to attend. In addition to the original committee and representatives from the public welfare agencies, presidents of membership organizations and their welfare or youth-committee chairmen were especially encouraged to attend through letters outlining the purpose of the meeting. A panel to discuss the need included members of local agencies plus the consultant on juvenile delinquency of the Texas Youth Development Council.

Over 250 people representing more than 100 different organizations of 65 types in the Rio Grande Valley came to the meeting. Their response to the idea of providing group-care opportunities for girls was overwhelmingly positive, and a steering committee was nominated and elected on the spot. Committees were formed soon afterward to cover financing, public relations, and buildings and grounds.

The ***finance committee*** obtained pledges and cash contributions on a regular basis to support the new institution, gained its admittance to local United Funds, and established a cash reserve for the first year of operation with assurances of continuing financial support.

The ***public relations committee*** took responsibility for continuously publicizing through newspapers, television, and radio the need for a group home for girls and the kind of facility needed. Through these media and a schedule of talks and discussions with various service groups, the home soon became a Valley-wide project on the bases both of interest and support.

The ***building and grounds committee*** obtained the contribution of services of an architect, an interior decorator, and all the local labor unions, whose members donated their labor to construct the residence. It also secured a donation of land and, through a local foundation, a substantial cash contribution to buy materials. Many materials were also secured as donations. The furniture was given by various individuals and service clubs in addition to their cash contributions. Incidentally, with the exception of an inconspicuous cornerstone crediting the labor unions, there are no signs or plaques on the residence indicating the donors of anything or otherwise identifying the place as an institutional home for girls.

Special committees worked on special projects in cooperation with the three main committees. During the first year all committees were assisted by the regular standing committees of the agency and coordinated through the executive committee of the agency's board of directors. At the end of the year the committees were absorbed as part of the agency's standing committees or dissolved, with the exception of the building committee which continued to function until the residence was completed.

Developing Understanding

A special subcommittee of the building and grounds committee selected the residence's location. The size and location of the home today reflect the growth in this committee's understanding of the needs of children under care and of its ability to pass this understanding on to the community through the organizations its members represented and through the public-relations committee. Through this subcommittee's discussions and activities, the community soon began to recognize that the children the group home would be serving would need the same kinds of things that all children need plus a great deal more—the "more" being a larger measure of understanding to make up for the dearth of this in their earlier lives—to be provided through a warm, interested houseparent, skilled professional staff including social caseworkers, psychologist, and psychiatrist, and a program and living arrangements designed to fullfill their needs. The committee recognized that the "plus" phase would have to be left up to the administration, and saw its task as the fulfilling of needs which these children have in common with all children.

Recognizing that children living away from home already feel different from other children because they are not with their own parents, the committee saw the importance of avoiding the many unnecessary appurtenances of institutional life which constantly remind institutionalized children of their singularity. It came to see that the children in the new group home would need the same acceptance in the community as other children; and that to locate the home away from the community would make it difficult for its children to participate in community activities, and so to feel accepted. Nobody on the committee wanted the children to feel rejected and pushed out by the community. As the importance of location to the avoidance or promotion of this feeling became clear through many committee discussions, the decision was reached to locate the home in a residential area near schools and churches. The land obtained was in such a location, with an elementary school, junior and senior high schools, and several churches within walking distance.

In considering the size of the residence, the committee came to the conclusion that the girls needed a home that looked like any other home in the particular residential area; that they should not feel different from the girl next door because of the appearance of their house. A local architect with a national reputation contributed his services. A residence to accommodate eight girls was designed in such a way that in the future, if desired, it could be turned into a regular residence with the minimum of effort and cost.

The house includes, in addition to the common rooms, a room for the housekeeper, one for the relief housekeeper—which doubles as a guest room—and two large bedrooms for the girls, each designed to accommodate four girls. The capacity was set at eight girls, with the purpose of making the home large enough to provide group living for girls needing an impersonal atmosphere, yet small enough for those girls able and willing to accept close family living.

The actual use of the girls' group home can easily change as need changes. It allows for more flexibility by far than the old-type institution. Increase and decrease in the size of the facility can take place without affecting other parts of the agency's total program. Increase in facility can be accomplished in stages not requiring the immediate financial support that large plants must have for maintenance and staffing. Cost per child, even though in a smaller group and a more normal setting, is proving to be less than in the larger institution for boys, and the agency is providing the girls with better care.

Plans are now drawn for the construction of a group home for boys to replace the present remodeled barracks building, which houses 20 boys. It will be constructed on the present site of Valley Boys' Ranch, for much of the ground here is soon to be turned into a residential subdivision. This is within the city limits of Harlingen and is conveniently located. The new boys' home will hold 10 or 12 boys, with an additional part-time staff member available to work with boys interested in farming and in 4-H projects.

There is a possibility that additional group homes will be established in adjoining communities as the need becomes evident. They will be under the central administration of Valley Children's Services. Consideration also is being given to designing the next group home to care for both boys and girls so that brothers and sisters may be kept together.

Since the present site of Valley Boys' Ranch is within the city limits, consideration is also being given for a small group facility to be located outside the city limits, but easily accessible to the community. The program would be designed to provide an opportunity for experience in agricultural activities, including work with livestock and citrus farming, for boys who need it.

The flexibility of the group-home design provides innumerable possibilities for outstripping old-type institutions, whether of congregate or cottage-plan variety, in meeting children's needs.

The girls' residence officially opened in February 1958—two years after the initial Valley-wide meeting. It took a long time, but the patient inquiry and interpretation have produced results. Almost everyone in the community feels as though he had had a part in creating the new facility. And, even more important, both the community at large and the board and staff of the Valley Children's Services have a better understanding of the kinds of services children in the Valley need.

We have all become people according to the measure in which we have loved people and have had occasion for loving. . . . To love selflessly and unconditionally, with a strength equal to the square root of distance, is the task of our hearts while we are children.

Boris Pasternak in Safe Conduct: Autobiography *as published in* Boris Pasternak: Selected Writings, *New Directions, 1949.*

HERE AND THERE

Conference on Adoption Research

In response to expressions of interest in learning about the outcome of adoptive placements, the Elizabeth McCormick Memorial Fund held a 2-day meeting, November 13-14, to consider a possible design for a followup study in adoption. Of the 15 participants (coming from Eastern, Midwestern, and Western States and from Canada), 9 were primarily research-oriented and 6 primarily involved with agency administration and practice. Each participant submitted in advance a study proposal and these were circulated before the meetings.

In a series of spirited sessions, the group reached relative consensus on a number of points and clearly defined disagreements on some others. It was generally agreed that we need to think of multiple approaches and to plan for research programs rather than discrete projects. That is, instead of one grandiose project, the participants favored many separate studies under varied auspices, each study fitting into a broad, general plan.

Three general types of study were pointed out as feasible and urgent: the longitudinal, beginning with current adoption cases and following them through a period of time, with repeated investigations at stipulated periods; a study using a "cross-sectional approach" which would examine the current status of adoptions completed 5, 10, and even 15 or more years ago; and a wide variety of "tooling-up" studies designed to identify the variables and develop the methods requisite to satisfactory adoption research.

During the two days specific plans were made for work in two of these categories and further activity in the third—one plan being for a cross-sectional study in which three of the agencies represented at the conference would collaborate. The need for such collaborative effort was among the salient points of discussion and resulted in a recommendation for greater pooling of research activities and resources, including exchange of data.

A recurring point concerning the practice of child-placing agencies was the question of whether less emphasis should be placed on screening applicants and more on helping them to develop their full potentialities as adoptive parents. Several members of the group reported that a trend in this direction is perceptible in current practice. According to their reports some agencies are accomplishing the main selection in the initial interview and devoting the chief attention in subsequent interviews to education for adoptive parenthood. This shift of emphasis, it was pointed out, is clearly related to the intake situation of the individual agency; and also, perhaps, to changes in the always-evolving conception of the child-placing agency's functions.

Mental Retardation

An intensive survey of the research on mental retardation being done in southern States will be completed early in 1959 by the Southern Regional Education Board. The information is being collected to show not only the content of the research but the fiscal, administrative, and other provisions made for this work in the 16 States the board covers. The survey is part of a larger one on mental-health and behavioral-science research in the southern region, being undertaken as part of the board's mental-health program.

The board is also surveying the needs of the region for personnel in the field of mental retardation.

Among the other activities of the board in relation to mental retardation are: sponsorship of a series of research conferences, each bringing together five or six workers engaged in similar research to discuss common problems; helping the States in the southern region to recruit and train teachers for the retarded and to pool resources in developing centers for the doctoral training of such teachers; administration of a grant from the National Institute of Mental Health to enable personnel of institutions for the mentally ill and the mentally retarded in the southern region to study at similar facilities in other States.

The board was established in 1949 under interstate compact to aid the States represented on it to share their college and university resources.

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In an effort to shed some light on the question of whether mentally retarded children with no known organic feature to explain their condition are retarded because of genetically or environmentally determined factors, a longitudinal, interdisciplinary study of 15 such children is under way at the child-development clinic of the State University of Iowa. It has two aims: (1) to amass and integrate medical, psychological, educational, and social information about the children, gathered over a period of 5 years, into a meaningful whole; and (2) to see if a concentrated effort to meet every aspect of these children's needs—medical, nutritional, educational, psychological, and social—can mitigate their symptom of retardation.

The project provides all these services directly, using an experimental nursery school especially established for the purpose as a device for increasing learning deficits, giving the children a social experience, and, through school lunches, improving their nutritional opportunities. In addition it offers psychiatric, social-casework, and home-management help to those of the children's parents who seem to need it.

All the children in the study come from families low in the socio-economic scale. A group of similar children in another city, to receive the project's tests but none of its services, has been selected as a study control.

Collaborating in the study are specialists in psychology, pediatrics, neurology, psychiatry, social work, education, and nursing from the university's various schools and departments and from its Child Welfare Research Station.

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Severely retarded children receiving classroom instruction in a 2-year experimental training program in seven public-school classes and 10 institution classes did not improve beyond the normal growth indicated by their intelligence quotients, according to the results of a study recently completed for the New York State Interdepartmental Health Resources Board. The investigators concluded that the solution of the main problem of those children, whose I. Q.'s ranged from 25 to 50, should be sought in "life planning"—training for self-care and maximum socialization—rather than in classroom instruction. The investigators noted that their findings with these children contrast markedly with findings in respect to less severely retarded children

Homemaker Service

Homemaker service has become a major specialized service of the child-welfare unit in Hidalgo County, Tex., where nearly one-sixth of all the children served during the year which ended June 30, 1958—or 116 of a total of 756 children—received care from homemakers sent in to help the family in times of the mother's absence or incapacity. This homemaker service continues to grow. Three new homemakers were added to staff between September and November 1958, bringing the total of full-time homemakers to 15.

In an inservice training program for the homemakers, the unit has called in the county home-demonstration agent county public-health nurses to lead discussions on: budgeting for low-income families; meal planning for low-income families; child care in the homes with little or no facilities; first aid and its uses. The Norwegian film "Emergency Housewife" has been used as a visual aid in helping them to understand their part in keeping families together.

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An agency to provide homemaker service has just been developed in the State of Israel through cooperative effort and sharing of administrative costs by several voluntary organizations and the Ministries of Health and Social Welfare. The new agency will operate on a fee-for-service basis, payment being made by the referring agency or by the families themselves, who may apply directly for service.

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The film "Home Again" produced by the Mental Health Film Board to interpret homemaker services to the public is also being used by some agencies in in-service training of their homemaker staff. In Cleveland the Family Service Association and the Jewish Family Service Association recently provoked lively discussion at a showing of the film to their homemakers by dividing them in groups, each group being assigned to notice particularly the feelings of father, mother, or children in the story's family. The 16-millimeter film may be purchased from the Mental Health Film Board, 267 West 25 Street, New York 1 (price $145), or borrowed or rented from State or local mental-health societies, public libraries, or educational film libraries.

The National Conference on Homemaker Services is to be held in Chicago on February 10 and 11 (not February 11–12 as reported in the last issue of CHILDREN), with Mrs. R. Livingston Ireland as its chairman. The conference is being sponsored by 8 units of the Department of Health, Education, and Welfare and 26 national voluntary agencies. Co-chairmen of the executive committee are Katherine B. Oettinger, chief of the Children's Bureau, and Clark W. Blackburn, general director of the Family Service Association of America.

Immediately after the conference, the National Committee on Homemaker Service will hold a one-day meeting to plan continuing activities in line with the conference's suggestions.

Health Research

Groundwork for stimulating new research on the effects of tranquilizers and other drugs on children is being laid by the Psychopharmacology Service Center of the National Institute of Mental Health, which plans to support such research through financial grants. An initial step in this direction was an all-day conference held under the center's auspices in Washington in mid-October at which clinical and laboratory psychologists, pediatricians, psychiatrists, social workers, and neuropharmacologists identified problems in the use of drugs by children and suggested ways of solving them through research.

Under deliberation were such questions as how drug effects on children can be accurately measured, how to determine whether the drugs can be safely given to children for long periods of time, and how to determine whether the drugs affect children's learning ability and other aspects of their development. The conferees also discussed the question of whether some of the research techniques used to study drug effects on laboratory animals can be adapted to use with children.

The Psychopharmacology Service Center's interest in this type of research as part of its broad program of research on drugs used in psychiatric treatment—their clinical effectiveness, their liabilities, and their basic mechanisms of action—encompasses the effects of the drugs on normal as well as on emotionally disturbed and retarded children.

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At the suggestion of the National Institute of Allergy and Infectious Diseases, the Children's Bureau and the National Office of Vital Statistics have initiated a joint project to obtain information relating to the incidence of cystic fibrosis of the pancreas among children.

The disorder is a rather recently recognized familial disease that manifests itself in infancy and early childhood. A pancreatic defect causes intestinal indigestion resulting in malnutrition and retarded growth. Repeated respiratory infections of increasing severity are characteristic and, before antibiotics, were a common immediate cause of early fatality. Progress has been made in diagnosis and treatment but the basic defect is not yet understood. Its incidence is not known; an estimate based on limited 1945–49 data is that it may occur 7–10 times per 10,000 live births.

Since most children suffering from this condition are believed to be hospitalized, the study will be conducted by means of questionnaires to hospitals. A preliminary inquiry to obtain gross data will be followed by a case survey to refine the data and obtain additional information on the epidemiological aspects of the disease.

Child Welfare

For 2 days in early October the State public welfare administrators and child-welfare directors met with the Children's Bureau in Washington, the first such conference in 14 years, to discuss ways in which the Bureau and the States can together promote progressive child-welfare programs.

The first day was spent in considering material prepared by the Bureau on procedures for implementing the 1958 amendments to title V, part 3, of the Social Security Act. (See CHILDREN, November-December 1958, p. 231.) State representatives exchanged information on ways in which they are now using Federal child-welfare services funds.

On the second day there were group discussions of questions on organization, administration, and training for child welfare; strengthening services to children in their own homes and in foster care; and the role of the State public welfare agency in providing juvenile-delinquency services.

Among the recommendations which came out of the group meetings were: a request for similar conferences, to be held more frequently, not only in Washington but elsewhere on a regional basis; increased help from the Children's Bureau in such areas as administration and organization; help from the Children's Bureau and the Bureau of Public Assistance in achieving better coordination in State and local programs for families and children.

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In the 23 months between September 1956 and August 1958, the adoption resource exchange operated by the Texas State Department of Public Welfare was used in the placements of 234 children in 146 adoptive homes. The exchange, established by the department's child welfare division in September 1949, has been used not only by the department's 20 child-welfare units, but also, through less frequently, by voluntary agencies in the State. (See "Placing the Older Child in Adoption," by Anne Leatherman, CHILDREN, May-June 1957, p. 107.)

Besides the children placed singly, the exchange helped in finding homes for a number of brothers and sisters together. One couple took 6 children ranging in age from 3 to 13 years; 4 couples took 5 children each; 4 took 4 children each; 5 took 3 children; and 37 couples took 2 children each.

Twenty-eight percent of the children were 6 years of age or older at the time of placement; 33 percent were between the ages of 2 and 5; and 38 percent were under 2 years of age.

Twenty-seven of the children had physical handicaps. These included not only minor orthopedic conditions, but also cardiac disorders, deafness, and blindness.

Eighty-four of the children were of minority ethnic origin: 26 were Negroes; 46, Latin American; and 12, mixed Latin-American and Anglo-American.

Youth and Parents

Young people and their parents from 67 counties in Pennsylvania gathered together in Harrisburg, the State capital, last September, in a conference called by the Governor, to discuss the opportunities and responsibilities of youth today and to participate in the State's preliminary planning for the 1960 White House Conference on Children and Youth. Most of them came prepared by discussions at home and at school of a number of questions sent to them by the Governor's Committee on Children and Youth, sponsor of the conference. These were grouped under the 3 subjects of the 12 conference workshops: student morale and responsibility; post high-school opportunities; and job opportunity and availability.

Representatives from 16 statewide or regional organizations concerned with youth and 16 young people between the ages of 16 and 20 composed a group of advisers to the Governor's committee in planning the conference. The participants in the conference, all invited as individuals, included persons of various races, religions, interests, economic and environmental backgrounds, and educational and vocational plans. In the discussions many of the young people expressed a strong desire to be given responsibility both inside and outside the home and as one 17-year-old put it, "to be given a chance to really contribute something to the world if we can."

White House Conference

The first meeting of the National Committee of the 1960 White House Conference on Children and Youth took place December 16–18 in Washington on call of President Eisenhower, the committee's honorary chairman. The President received the committee at the White House on the first day of the meeting.

The committee adopted the following theme:

"The purpose of the 1960 White House Conference is to promote opportunities for children and youth, to realize their full potential for a creative life in freedom and dignity.

"This effort will be based on: (1) study and understanding of the values and ideals of our society; the effect on the development of children and youth of the rapid changes in this country and the world; and how families, religion, government, community services—such as education, health, and welfare—peer groups, and the behavior of adults in their interactions with children and youth deter or enable individual fulfillment and constructive service to humanity.

"(2) Examination of the degree of achievement of previous White House Conferences' goals and recommendations.

"(3) Determination of the action that individuals, organizations, and all levels of government can take to implement Conference purposes".

Included on the widely representative 92-member committee, appointed by the President in early November, are 9 young people of high-school or college age, selected for their leadership in school, church, and community youth activities. The committee's chairman is Mrs. Rollin Brown, immediate past president of the National Congress of Parents and Teachers. The Secretary of Health, Education, and Welfare, Arthur S. Flemming, is honorary vice-chairman; and the Chief of the Children's Bureau, Katherine B. Oettinger, is secretary.

The vice-chairmen are: Dr. Hurst Anderson, president, American University; Dr. Philip S. Barba, former president, American Academy of Pediatrics; Mrs. James Blue, president, National Association of Governing Boards of State Universities and Allied Institutions; Robert E. Bondy, chairman of the Council of National Organizations; Erwin D. Canham, editor, Christian Science Monitor; Donald K. David, chairman, executive committee, Ford Foundation; Dr. Luther Foster, president, Tuskegee Institute; Monsignor Raymond J. Gallagher, assistant director, Catholic Charities, Diocese of Cleveland; Mrs. Frank Gannett, chairman of board, Gannett Newspaperboy Scholarships; Dr. Edward D. Greenwood, coordinator of training in child psychiatry, Menninger Foundation; Dr. Daryl P. Harvey, staff physician, Howard Clinic, Glasgow, Ky.; Donald S. Howard, chairman, National Council of State Committees for Children and Youth; Ruth Stout, president, National Education Association; Rabbi Marc H.

Tanenbaum, executive director, Synagogue Council of America; Rev. William J. Villaume, executive director, department of social welfare, National Council of Churches.

Each member of the committee serves as an individual and not as an organizational representative.

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The *Conference Reporter*, a newsletter on activities in preparation for the 1960 White House Conference, made its first appearance in November. It is issued by the Conference staff.

Honored

For her work in creating "a coherent public-health program out of the beginnings of the child-health movement in this country" Dr. Martha M. Eliot, former chief of the Children's Bureau and now professor of maternal and child health at Harvard School of Public Health, received the Sedgwick Memorial Award, highest honor annually bestowed by the American Public Health Association, at the association's 1958 meeting in late October.

The citation, read by Dr. Leona Baumgartner, Commissioner of Health of New York City, not only praised Dr. Eliot's leadership in the Children's Bureau's efforts "to bring the fruits of new medical knowledge promptly to the people and to promote a higher quality of medical service for them," but also mentioned her previous research studies at Yale and her work with UNICEF and with the APHA itself as past president and active committee member. "All of her work," it said, "seems to spring from a deep understanding of two closely interwoven concepts—the child as an individual and children in and of a community."

Infant Care

At the White House in mid-October, the President of the United States presented the 40-millionth copy of the Children's Bureau publication, *Infant Care*, to a young couple from Carbondale, Ill., Mr. and Mrs. Jerry E. Levelsmier, selected by the Children's Bureau with the help of their State and county health departments as representative American parents. The event received national publicity through press, radio, and television. Mr. and Mrs. Levelsmier were already acquainted with the publication, having used it as a guide in the early care of their two children, now aged 4 and 2.

BOOK NOTES

COLLECTED PAPERS; through paediatrics to psycho-analysis. D. W. Winnicott. Basic Books, New York. 1958. 350 pp. $6.50.

The three groups into which the 26 papers collected in this book are divided represent three phases in the professional life of the author, who is a British pediatrician and psychoanalyst. The papers in the first group, he explains, represent his attitude as a pediatrician before beginning training in psychoanalysis. Those in the second were written after he became psychoanalytically oriented, and those in the third constitute a personal contribution to current psychoanalytic theory and practice.

The 2 papers in the first section discuss anxiety as a normal characteristic of childhood, and children's fidgetiness, tics, and chorea; the 8 in the second group, such subjects as appetite and emotional disorder, the child's eyes in relation to psychoneurosis, and anxiety associated with insecurity. Among the 16 subjects discussed in the third section of the book are primitive emotional development, aggression in relation to emotional development, withdrawal and regression, and "the antisocial tendency."

Maintaining that pediatrics is too fully occupied with the physical, the author urges younger colleagues to take psychoanalytic training and to modify what they learn to fit individual cases.

NUTRITION AND THE PAPUAN CHILD; a study in human welfare. By H. A. P. C. Oomen and S. H. Malcolm. Technical Paper No. 118. South Pacific Commission, Nouméa, New Caledonia. 1958. 146 pp. $1.20.

This report is based on studies carried out by a physician-nutritionist and a dietitian-nutritionist in selected areas of Australian New Guinea and Netherlands New Guinea. Beginning with a survey of the nutrition and diet of mothers and their young children, the authors proceeded to study the character and availability of the food resources of the general population, and finally to consider the total subsistance economy of the areas.

The last chapter before the summary deals with prospects for improvement. The authors state that in the Papuan villages "the child and the mother are at the very roots of human welfare." In their opinion, "It would seem wise, before the development of New Guinea 'at an accelerated pace' is considered, to be concerned about food requirements and body-building substances; and about the heart of the community life, that is, the mother-child relationship."

GROWING FROM INFANCY TO ADULTHOOD; a summary of the changing characteristics of children and youth. Edward C. Britton and J. Merritt Winans. Appleton-Century-Crofts, New York. 1958. 118 pp. $1.10.

One of a series on current problems in education, this book summarizes typical patterns of behavior of children and young people through the age of 20. Appendices give percentiles for weight and height of American children from birth to 18 years of age; chronology of pubertal developments in height, weight, and sex characteristics; lists of materials on child development; textbooks; reports of research; and other books, pamphlets, journals, and films.

The book is addressed to a wide range of readers, including parents; teachers, leaders, and administrators in schools and community agencies; students; and children and youth, to whom, the authors say, "the book gives insights into their own behavior otherwise not ordinarily obtainable."

READERS' EXCHANGE

McFERRAN: *A question of when*

I have read with a great deal of interest Jane McFerran's description of the imaginative use of the group process by the protective service division of the Jefferson County Welfare Department in helping parents who neglect or abuse their children. ("Parents' Groups in Protective Services," by Jane McFerran, CHILDREN, November-December 1958.)

It appears that the experience of the parents in being involved in a group with other parents having similar problems was a constructive one. The parents were presumably able to carry over added strength in individual casework treatment with their worker as a result of the group meetings.

I would like to raise the question at what point in the casework process of individual help to these parents the group experience was introduced? This is not entirely clear from the article. Parents who neglect or abuse their children suffer from seriously underdeveloped and damaged image of self. In the individual helping process, results come from beginning where the person is, and, through the worker, supplying the adequate parent figure with whom the parent can relate. This is essential to his moving on to a broader identification with neighbors, friends, and eventually the community.

My question is this: is the child, who is in this case the parent, able to relate to nursery school or school, which is in this situation a group experience, before he has sufficient time to receive the necessary ego support from the parent figure, in this case the individual caseworker? Careful timing is of utmost importance.

Most of the parents that we see in our protective program in Missouri ("Protective Casework Service," by Lorena Scherer, CHILDREN, January-February 1956) need a period of working out a purposeful relation with one individual, the caseworker, before they are ready to relate purposefully to others. The relationship to the caseworker is meaningful to the parent as parental-substitute identification and has a bearing on his own expectation for progress. Most of the parents need considerable individual understanding before change takes place. I am surprised that such depth of understanding was forthcoming from other parents who were likewise deprived.

It is only through actual experiences with processes such as Mrs. McFerran describes that we will move forward in this area.

Lorena Scherer
Child Welfare Supervisor, Missouri State Department of Public Health and Welfare.

HERZOG: *Application re adoptions*

Elizabeth Herzog has performed a very useful service in pointing up the key issues that must be faced by those who eagerly seek rather definitive answers to questions concerning the effectiveness of services aimed at producing changes in the social and psychological functioning of individuals. ("How Much Are They Helped?" by Elizabeth Herzog, CHILDREN, November-December 1958.)

Her comments apply equally well to other areas of service to individuals and families. For instance, there is a strong desire in many quarters to find answers to such questions as: How do adopted children turn out? Have agencies used good judgment in choosing among adoptive applicants? Is foster care all that its enthusiasts say it is?

Miss Herzog's distinctions between *ultimate evaluation*, *pre-evaluative research*, and *short-term evaluation* and her listing of the various task requirements associated with these categories usefully delineates research undertakings for agencies to consider carefully. For the agency without full-time research staff, the last-named type of research seems most feasible and can be extremely helpful in preparing the groundwork for research at the preceding two levels.

It is a fact that the development of useful typologies in child-welfare research has been greatly hampered because the simple phenomenology of agency programs has not been systematically recorded. It is important to know even gross characteristics of the following types of situations: (1) unmarried mothers who keep their babies as opposed to those who relinquish theirs for adoption; (2) children who remain in foster care as opposed to those who move on to adoption; (3) adoptive applicants who are approved by agencies as opposed to those who are not.

In obtaining such gross data and subjecting it to fairly simple analysis, agencies will be shedding light upon their own programs as well as preparing the groundwork for those researchers who are in a position to devote full-time effort to research of a more complex nature. In doing this necessary preliminary work, I would like to underscore Miss Herzog's plea that agencies not be afraid of doing unpretentious work. To quote Fielding: "Thy modesty is a candle to thy merit."

David Fanshel
Director of Research, Child Welfare League of America.

RABIN: *Adjusted to what?*

Dr. Rabin's interesting report on child rearing in the collective settlements of Israel discusses social adjustment in such a way as to bring into the picture that to which adjustment is supposed to be made. ("Kibbutz Children—Research Findings to Date," by Albert I. Rabin, CHILDREN, September-October 1958.) In his last paragraph, he indicates that all evaluations of the adequacy of child-rearing methods should be made with reference to the society in which the children are to function.

This reasonable proposal raises the question of how to judge the adequacy of child rearing in terms of cultural values not one's own. Actually, Dr. Rabin makes his judgments regarding "adjustment," "maturity," and the like in terms of our society, not that of the kibbutz. Thus, in an earlier article in the *Journal of Projective Techniques* (June 1957) he reports on a variety of techniques for judging adjustment and maturity through Rorschach findings, using standards and "signs" that have been developed far away from the kibbutz culture. Moreover, in no place does he mention those kibbutzim that have given up the communal method of child rearing.

Which methods are better for the kibbutz culture? These considerations suggest that a historical perspective may be helpful, both for inquiring into the actual aims of those who founded the kibbutzim and for verifying the extent to which the kibbutz-reared youngsters may have realized, perpetuated, or transformed these values.

That part of Dr. Rabin's research which deals with the older groups—the 9 to 11's as well as the 17-year-olds—raises the most troublesome problems. Dr. Rabin judges the kibbutz youngsters to be "superior" to his control group, but I would worry about some of the kibbutz characteristics on which this judgment is based. Most striking, here, is the apparent preoccupation of many kibbutz adolescents with such "altruistic" goals as world peace. This kind of impersonal affect, at a time when a more personal orientation is expected in our culture, considered in conjunction with the more diffuse personal identifications which Dr. Rabin documents, suggests a certain emotional blandness and possibly impoverishment.

It seems that one of the most challenging problems which Dr. Rabin raises—what happens to the kibbutz youngster that turns his inferiority as an infant into a superiority as an adolescent—may well turn out not to be a problem at all. The emotional deprivation in infancy which Dr. Rabin so ably discusses may very well still be hidden underneath those oversocial responses in adolescence.

Werner Cohn
Head, Department of Sociology, Northland College, Ashland, Wis.

BRIM: *Parent education*

Orville Brim correctly calls attention to the multiplicity of factors which influence the effectiveness of parent education. ("The Sources of Parent Behavior," by Orville G. Brim, Jr., CHILDREN, November–December 1958.)

He discusses the conscious factors in a single paragraph, however, and then gets to work on the unconscious factors. I would not have dismissed the conscious factors so lightly, for I am one who believes the unfortunate conventional analogy of the iceberg should be reinterpreted so that the part of the "berg" which is in the air represents the unconscious, and the seven-eighths that is in good, touchable water represents the conscious. Many young parents these days express a willingness to learn, even an anxiousness to have information on parenting. They often say, "I had no brothers or sisters and I have never been around a baby; I need all the help I can get." This may fairly be considered a conscious motivation.

However, assuming the unconscious factors to be large, why not consider them proper foci for parent education? The speed with which people now recognize rationalizations seems greater than it once was. Maybe we can teach parents about subliminal struggles for dominance, love-hate, sibling rivalry, high and low masculine and feminine indices, and the like. One by one we may be able to lift these unconscious motives by a sort of mass educational psychoanalysis to the point where, seeing them, parents will be less influenced by them.

True, unconscious factors inhibit all learning in all areas to some extent; but educators, generally, do not allow such factors to stop them in their efforts. Sometimes, too, these factors enhance learning.

Dr. Brim does not call attention to variations in the power of the forces that seem to play upon the parent because of the time factor. No doubt the parent is more educable at certain times than at others. It is not too soon to start parent education before people marry, or at least before the first baby is born. It also seems that there is a period during the first months of the life of the first child when parents are more teachable. After there are several, or even just two, children in the family the patterns of child care probably become pretty well set.

The possibility of learning is also indicated by the general presence in our culture of the idea that our own parents are old-fashioned in most ways, including their methods of child care. Change is considered desirable. There is also in our culture the belief that science is changing all things and affecting all phases of our lives—even to the rearing of children. We should take advantage of these points of view, correct or not, in parent education, if we can.

Moreover, ideas tending to neutralize good teachings are constantly being fed to parents by unsavory sources. Thus we must teach, and re-teach.

Loyd W. Rowland
Executive Director, Louisiana Association for Mental Health, New Orleans.

PERKINS: *Priority for mental health*

In reading Dr. Perkins' excellent article on school-health programs ("Improving the Health of Children of School Age," by Georgia B. Perkins, CHILDREN, September–October 1958), I could not but wish that she had presented a number of concrete suggestions about some organized way to reach solutions to our predicament.

Truly we are paying a heavy price for specialization in medical as well as in school circles. The ability to communicate seems to be in inverse ratio to our degree of specialization. Knowledge in science and education is leaping over hurdles, previously formidable, and yet understanding in the interests of boys and girls creeps along at a snail-like pace. Physicians, parents, teachers, and all social agencies serving children within any community have vast resources in each instance, but we have not found a way to communicate effectively in the interests of our principal reason for being—our children. Perhaps a community health, physical, and mental council representing all of these interests could do much to connect data, define problems, establish priorities, and develop the educational programs necessary to utlilize specialized knowledge through communication.

Teaching information about health is a relatively simple matter. Developing healthy attitudes toward one's body, one's self, and other people, including loved ones, is more difficult. Although Dr. Perkins puts some emphasis in the article on mental health, this aspect of health must be given a much higher priority in the values attributed to a health program.

O. M. Chute
Superintendent, Community Consolidated Schools of Evanston, Ill.

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SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN: a listing. Rudolf P. Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1958. 22 pp. Single copies free on request.

This result of a first attempt by the Bureau to compile a list of special clinical programs for the mentally retarded on a nationwide basis provides information about the types of facilities reported, where they are, and who directs them. No evaluation is made of the quality of services rendered by these clinics. The information given in the listing was provided by the clinics.

FINANCING PUBLIC CHILD WELFARE SERVICES, 1956; with selected trend data. Seth Low. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 46. 1958. 38 pp. Single copies available from the Bureau without charge.

Data reported in this publication show that in 1956 State funds accounted for 51 percent of public expenditures for child-welfare services; local funds for 44 percent; and Federal, 5 percent. Of the total, 72 percent went for foster care; 24 percent to pay personnel; 0.4 percent for educational leave; and 4 percent for other purposes, such as supplies.

The report also presents trends in Federal, State and local expenditures from 1952–56; trends in foster-care expenditures from 1947–56; and trends in Federal expenditures for child-welfare services for 1936–56.

CHILDREN SERVED BY PUBLIC CHILD WELFARE PROGRAMS, 1957; with trend data 1946–1957. Helen R. Jeter and Henry C. Lajewski. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 45. 1958. 27 pp. Single copies available from the Bureau without charge.

On March 31, 1957, according to data presented in this report, 329,688 children, in 53 States and Territories, were receiving child-welfare casework service from public-welfare agencies—the largest number ever reported. Thirty-eight percent of these children were receiving service in their own homes or the homes of relatives. For the 40 States that reported completely from 1946 to 1957, the figures show a significant expansion of child-welfare services in rural States.

HOMEMAKER SERVICE; for families with children, for expectant and new mothers, for the chronically ill and disabled, and for the aging. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 46. 1958. 36 pp. 15 cents.

Explains what homemaker service is, how it helps families, who receives the service, who are selected as homemakers, how they are trained, what are their working hours, and who pays for the service. Tells also how different communities start such a service and examines its possible future.

RESEARCH RELATING TO CHILDREN; BULLETIN No. 8. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 131 pp. $1.

Reports studies in progress March 1–July 31, 1958, on such subjects as growth and development; personality and adjustment; educational process; exceptional children; the family; social, economic, and cultural influences; and health and social services.

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INTERACTION between mother and child. The continuous exchange of emotional gratification between mother and infant nurtures the deep maternal impulses in the personalities of most women, enhancing their capacity for motherhood. The sources of these impulses and how they are developed are discussed by a psychologist and a pediatrician-psychiatrist in an article beginning on page 48.

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In her psychoanalytic practice Irene M. Josselyn works with all age groups, but in her writings she has focused chiefly on children and adolescents. Among her books are: "The Psycho-social Development of Children," "The Adolescent and His World," and "The Happy Child." In addition to carrying on training and research activities at the Chicago Institute for Psychoanalysis, she serves as consultant to a number of social agencies and as clinical professor of psychiatry at the University of Illinois, College of Medicine.

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The contradictory urges besetting normal young people during . . .

PSYCHOLOGICAL CHANGES IN ADOLESCENCE

IRENE M. JOSSELYN, M.D.
Member of Staff, Institute for Psychoanalysis, Chicago.

ONE OF THE REASONS we adults become so confused and contradictory when we discuss the psychology of the adolescent is that we are dealing with a psychological stage of development which is made up of contradictions. Our confusion about the adolescent is perhaps indicative of the degree of our understanding of adolescence. It is therefore important when we are feeling confused about an individual adolescent confronting us, about programs involving adolescents, or about education, social service, or the various other fields concerned with adolescents that instead of feeling inadequate we try to understand the basis of our confusion.

The normal adolescent is inevitably a mixed-up person, but not at all in the sense of being a psychologically sick person. The psychiatric literature contains many statements about adolescence being the time when psychological breakdown begins; that if you look back at the history of a person who has had a mental breakdown you will find evidence in his adolescence that he is going to break. Retrospective psychiatry is always distorted. Undoubtedly, the adolescent is in a precarious position psychologically because he is so confused, and because adolescence is a period in which that confusion must be resolved. The solution accepted may prove inadequate or take an undesirable form. But that does not mean that it is a very dangerous time for all adolescents, for there is an inherent strength during this period that actually enables a large percentage of them finally to come out of this confusion in a relatively healthy state.

Certainly we have reason to be uneasy about adolescents because of the changes that are going on in them, but perhaps we have become too uneasy and have failed to recognize that there is a great deal of strength in most adolescents in spite of their apparent instability. There is probably nothing that creates as much anxiety in a person than to be with someone who is anxious about him. The adolescent is terribly frightened and if we are frightened in dealing with him he cannot help but be scared. One of our best tools for dealing with adolescents is nothing derived from complicated ideas about them, but is merely a feeling of being comfortable in working with them. If we have this, our attitude will show that we are not afraid and so will not tend to increase their panic. If we are calm—though not indifferent in dealing with them—they at least will feel that we offer the kind of stable baseline they cannot see in themselves.

Wanted: A Framework

The confusions of adolescence are probably present in every culture. Certain cultures, however, help the adolescent to get over them by giving him a much more defined role than does our society. Obviously, a primitive tribe with its rituals defines for the adolescent a pattern of behavior as an adult that really gives him a rule to go by when he feels confused. However, this does not mean that we should set up such basic rules. We do not want our adolescents to conform to the group in the degree that tribal members conform.

Let us look at the sociological aspects of our own culture as they affect adolescents. We teach our own governmental and social philosophy to our children. We try ourselves to live by it. In this we may be more or less successful, but we do believe in the rights of the individual so long as their expression does not violate the rights of other individuals. Our whole social philosophy puts only very broad limits on behavior. The only fence beyond which one is not supposed to go is that one preventing us from violating the rights of others. Within its boundaries anything goes in response to an individual's own wishes, impulses, and goals. We even debate the question of what the rights of other people are, so that our fence itself is a shifting one. Thus, the only framework for behavior our culture provides is a very intangible philosophy, which most of us believe in and struggle to make effective. But it does not spell out in any detail how a person acts as an individual adult.

This may be one reason why the adolescent finds it hard to be an adolescent in our culture; why parents find it hard to be the parents of adolescents in our culture; and why we who work with adolescents get confused in our own thinking as to what should be the framework for adolescent behavior. We do not really know of a framework and we do not want a rigid one. But this is what the adolescent wants.

For several years I have been in a position to observe one manifestation of adolescents' need to find some kind of a framework of society's expectations of them. For a number of years I have occasionally seen some adolescents of very superior intelligence, who have done excellently in school, show no signs of delinquency, and are well liked by their teachers and their peers, and who on reaching the end of compulsory school age should continue schooling and go on to college. These young people come from uneducated families of low cultural standards. They are referred to me by organizations which have money to send them through college and on to constructive careers. I see those who refuse to go on, probably a relatively small number of the total group. The question brought to me is "Why?"

My observations have led me to think that perhaps these particular adolescents have found, because of the positive relationships in their homes and in their social group, a small cultural unit with clear initiation rites. In their subculture when a young person reaches the end of compulsory education he enters adulthood and takes a job; the adolescent does not have to struggle so hard with adolescent problems because he knows what is defined for him.

I am often asked: Are these youngsters neurotic, very sick people? In my young days I used to think so because I thought education was so important. As I have come to know them better, while I think their school-leaving is an unfortunate waste, I do not think that they are sick. One reason it is so hard to change their minds is that they are *not* sick; they are merely in a cultural framework and they do not want to leave it.

Roots of Confusion

Let us look briefly at some of the aspects of adolescence that a psychiatrist working with adolescents sees as the roots of the young person's confusion, and at what the normal adolescent tries to do about them.

One very obvious characteristic phenomenon is the sudden spurt of growth which comes in early adolescence. The parent tends to continue to think of the child as he was until suddenly he is forced to see the maturing body. The typical adolescent also tends to deny the changes in his body until all at once he notices the difference.

Adolescents experience a sense of strangeness about their bodies and try to hide them or advertise them. They have lost the security of a familiar body.

At some time preceding puberty the functions of the glands of internal secretion begin to change and a gradual change continues for a period of 3 to 4 years. The young person has new physical experiences which are not consistent. Sexual feelings come over him which are truly psychosomatic in origin: they are affected by his experiences and other feelings but are stimulated by glandular secretions. These sexual feelings are not completely heterosexual; they are diffuse and can fix on anything, such as music or sports. There is no place that the sexual aspects of aestheticism are so well illustrated as in the adolescent. The adolescent who loves music does not love music on an academic level; his total being loves music because part of the sexual feeling that his glands have stimulated is channeled so as to find expression through the appreciation of music.

One reason why a certain type of adolescent is so creative is that the intensity of these diffuse sexual feelings can be drained off into aesthetic areas and can enrich them.

However, these sexual feelings are very disturbing for the young adolescent, for many reasons. For instance, they disturb his relationship to his parents. The young person's new sexual feelings have a tendency to fix on some person, and it is natural for this to be a previously established "love object" of the opposite sex. Two people who over the years have meant the most to the normal adolescent are his parents. The deepest love that he has experienced has been his love for them. One does not have to go further into Freudian psychology or talk about the Oedipus conflict to see what one of the problems of the adolescent is—to find an acceptable channel for his sexual feelings. To channel them toward his primary "love object" is too dangerous. A healthy adolescent boy cannot do this, for the person for whom he has always had the greatest love is his mother. We know that some adolescents *do* turn their feelings in this direction and thereafter become those devoted sons who at the age of 60 finally bury their "love object"—their mother—amid commendations for being so devoted as to sacrifice their whole life for her. Actually, what they have sacrificed is their maturation.

The healthy adolescent does not want to turn his new feelings, with their new intensity, toward his primary "love object." The result is one aspect of behavior that bothers parents so much: the adolescent instead of showing love for his mother depreciates her, wants her out of the picture, does not want to be touched by her, does not want any show of affection, and does not want her to straighten his collar or necktie, but would prefer to have a girl friend do that. The reason is that the mother is no longer straightening the necktie of a child in the period of sexual latency; she is now straightening the necktie of a child who because his feelings are supercharged wants to keep his distance from his mother.

The adolescent has another "love object," his father. He would like to express his love for his father with this new-found emotional energy, but the normal adolescent faces the fact that this binds him to something that is not valid for the future. Therefore, he wishes also to remove himself from a close tie to his father. He manifests this in depreciating the father, belittling him in arguments, and wanting to be different from him. So here is a clue as to why the adolescent tries to break with his home.

A center for teen-agers provides these youngsters with a chance to be together and to find outlets for their energy.

Fortunately, most adolescents have a real urge at this point to get their feelings out where an expressed form is an acceptable form, and not to be bound to their childhood relationships with their parents. This leads to the whole question of independence.

Acting Out

What does the normal adolescent do with his new sexual feelings? Very often he turns them into an academic interest, artistic interest, or an interest in sports. Whatever he goes into, however, he goes into with an intensity that is exhaustive. Some adolescents seem fatigued all the time because they want to run away from this problem, and one way to run away from it is not to have the energy to face it. However, sometimes the adolescent *is* fatigued by all of his other activities and therefore really does not have the energy for the things adults would like him to do. For instance, an adolescent who is working hard in finding an outlet for himself in his interpersonal relationships, in his sports, and so forth, rarely has the energy to mow a lawn.

The adolescent has another problem about his sexual feelings. He knows that in our culture puberty is the beginning of adulthood—one suspects that even if adults did not tell him so he would have an unconscious drive toward adulthood—but he is terribly afraid of his own inadequacy sexually, and particularly fearful that he will not be able to be a real man in the sexual sense. All his new feelings frighten him, but he is also afraid that they are not strong enough and perhaps there is something wrong with him. He tries to prove to the outside world how effective he is because internally he feels so ineffectual.

While perhaps one would not say this attempt to prove sexual virility is normal adolescence, it certainly is progressively becoming normal adolescence. I do not know whether there is more sexual acting out on the part of adolescents than there used to be, or whether we adults today are being confronted by a different form of sexual acting out on the part of the adolescents we see than our parents were. Certainly adolescents today are responding to their sexual urges in ways that were not typical of the past generation. In the past there were perhaps different symbols for sexual acting out than there are now.

I was brought up in a mid-Victorian community where no high-school girl ever went out on a date without being chaperoned; where we were told that our kisses were for the man we married, and only at the altar should we experience a kiss from our boy friend. Kissing, we were told, was indecent; it was a violation of all that was womanhood. We all violated womanhood in that community and the adults did not know it.

Those kisses were not really heterosexual kisses. They were experiments in trying to see if we could be heterosexual. The typical young adolescent is not a heterosexual person psychologically, no matter how heterosexual he may be acting.

The tragedy of the present situation is that too many adolescents are trying to see if they are heterosexual in a way that is creating the tragedies of unmarried motherhood and fatherless children. And now I am referring to normal young people, not the emotionally disturbed adolescents who act out their conflicts through their sexual behavior.

Many normal adolescents are behaving in such a way sexually as to create serious problems for themselves within our culture. Their motivation is the wish to be sure that they really are normal and are going to be adult. They just do not face the fact that it takes time to be an adult. But in spite of the growing evidence of conflict between much adolescent behavior and our society's cultural attitudes, sex may not really be the adolescent's major problem.

What seems hardest for adolescents to handle is the struggle to free themselves of the family. They overdo it in a sort of a protest against their own anxiety and then in a panic they fall back into a more dependent role. As I have already indicated, one of the reasons the adolescent tries to break away from his parents as far as emotional ties are concerned is that he does not want to find an outlet for his sexual feelings there.

Struggling for Freedom

There is another reason why he wants to break away, a very healthy one. In the past the adolescent has been a child in the family. He has felt as a child and his parents have treated him as a child. The parents have outlined the broad limits of his behavior; the child has accepted those limits. During the preadolescent period, at grammar-school age, children are relatively easy to get along with, because while they might not like to wash very often or change their clothes very often they do make a rather realistic adjustment to childhood. For the most part, they obey their parents, and they are fairly predictable. This is because they are children and have accepted the child-parent relationship.

But the adolescent feels the surge toward greater maturation and adulthood, and he is told that he has to grow up to be an adult. He is not told that he has to remain a child. How can you become an adult if in your home you are a child? The adolescent wishes to break away from home in part to break away from his own childhood. He has to be flagrant about this because one side of him hates to give up his childhood. So he overdoes the break in order to convince himself that he wants to grow up, when actually he is giving up a sense of security for terrific uncertainty.

The adolescent also has another reason for wanting to break with the family, and that is that he wants to break with his own conscience. One of the most serious problems that we try to deal with when we are working with an adolescent is his need, in order to be an adult, to give up his childhood conscience. The origin of his conscience is primarily the relationship with his parents. If he retains the conscience that was made for him in his early childhood, he has to remain a child because it is the conscience of a child.

When most of us talk about conscience, we think about the restrictions we have for ourselves: we should not steal; we should not lie, except perhaps socially; we should not throw stones at people. We say the conscience should prevent people from doing the things that injure others. But that is only a small part of the conscience, albeit a very important part. There are a lot of other aspects to the conscience. The conscience of a very small child says that he must not cross the street. Until a child gets real self-control in relation to crossing the street, a parent does not dare to leave him alone. He may be extremely obedient as long as mother is watching, but when his mother is not there something across the street attracts him and he goes ahead. In this instance, the prohibition against crossing the street is not yet a part of the child's conscience. It is a part of his adaptation to his mother. Eventually, it will become a piece of his conscience and his mother will be able to trust that no matter what the circumstances are, he will not cross the street.

Fortunately, this aspect of conscience does not last until adolescence. The child learns to modify it as he gets older and the parents allow him to cross the street. But one finds in psychoanalytic practice with adolescents surprising areas of conscience that are really remnants of such aspects of a childhood conscience.

In his eagerness to break away from the dominance of his parents the adolescent overdoes rebellion and frightens himself, so that he then does a complete reversal and becomes a passive, dependent, agreeable, compliant child. The adult's cue then is to let him come back and confide his troubles and restore his strength and not to belittle him.

The adolescent needs to be sure he can be dependent when he wants to be. The adult does not have to be afraid of this for the adolescent will continue to strive for independence. His occasional swing back to an intensified dependence upon the parents provides a stability for him that enables him to again try his strength.

Effect of Peers

The parent is not the sole source of stability for the adolescent. Another important source of strength is his peer group. The normal adolescent is a conformist to his peers. His peer group structures a framework of behavior patterns. It also supports him in his explorations into a wider world by sharing the exploratory steps and experiences with him.

Thus, close identification with a peer group is an important source of security and encouragement for the adolescent. The question for consideration is not that he is closely identified with a peer group but instead what type of peer group it is, since the solutions the group makes to the problems of adolescence will broadly affect the solution each member makes. The fact that the adolescent is a conformist is nothing to worry about. What should be of concern is the type of peer group to which he is conforming.

I have touched on only four aspects of the multiple problems of adolescence. Others are equally important. We can learn of them in regard to any adolescent we are working with, if we will listen to him and try to understand what he is saying both through words and actions. We can help him if we are not frightened by what we learn, but rather use our knowledge to support him as he struggles through this confusing time.

True enough, there is confusion over what we are educating children "for"—a world at war, a world of peace and plenty, a world of conflict and hard work or of vastly increased freedom and spare time. Yet a supple, well-coordinated body is as useful on a ski-slope or tennis court as on a battlefield—or the moon. A well-stocked brain, a well-trained mind, can bring added delight to a day on Bermuda's beaches or save sanity during years in a prison camp. Interest in other people, flexibility in human relations, can be as useful to a general as to a social worker. Whatever the future, knowledge, skills, human understanding—the competence that leads to achievement in any sphere from the simplest to the most complex—will help today's children lead lives rewarding to themselves and helpful to others.

Dorothy Barclay in the New York Times Magazine, *April 13, 1958.*

THE DEVELOPMENT OF MOTHERLINESS

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EXPERIENCE has demonstrated that some young mothers care for their first babies—provided they are healthy babies—with assured comprehension of their needs, finding poignant satisfaction in the activities of motherhood and in inducing their babies' development. Their ways with their babies seem to be based on the interaction between the babies and themselves rather than the advice of professional counselors or of other people in their environments.

Many of these "good mothers" have not read any of the modern literature of infant care. Even in circumstances that would seem objectively threatening or frustrating, some of them are able to preserve for themselves the satisfaction of mothering activities and to provide well for their babies' needs. In cultures where the penalties of bearing a child out of wedlock are severe, some unmarried mothers insist upon rearing their infants themselves and are able to nurture their children with tenderness in spite of the negative attitudes of people around them. Some children are well-nurtured in poverty, in the midst of mass conflict, or in family crises.

Perhaps because a woman's impulse to mother her child tends to be strong and reliable, many writers on child care have not seemed deeply impressed by it, as man often is not impressed by what is commonplace to him. Rather they have seemed more impressed by the occurrence of deviations and have described the uncertainties and inadequacies of mothers with vigor and color. Even in the popular communications media the problems and disturbances of mothering are more vividly described than the deep, reliable wellsprings of maternal impulses in the personalities of most women.

In our observations of families in the Arsenal Family and Children's Center in Pittsburgh, in well-child clinics, in private pediatric practice, and in consultations with various agencies we have seen children getting adequate mothering in less than ideal situations—social, financial, and emotional. The following notes on how motherliness develops and how it can be nurtured by persons close to the mother—in professional or other capacities—are based on these observations as well as on the increasing literature on growth and development.

Therese Benedek refers to "the biological need for motherhood" and reports the findings of her studies of the attitudes and behavior of women in the phases of the hormonal cycle associated with the maturation of the ovum, fertilization, prenatal development, and lactation. She points out that at each phase of the reproductive cycle the hormonal balance tends to be conducive to appropriate feelings and behavior for that aspect of motherhood:

". . . The enhanced hormonal and general metabolic processes which are necessary to maintain normal pregnancy produce an increase of vital energies. The pregnant woman in her placid vegetative calmness enjoys her pregnant body which is like a reservoir replenished with libidinous feelings. While such feelings enhance the mother's well-being, they also become the source of her motherliness; they increase her pleasure in bearing the child and her patience in regard to some of the discomforts of her pregnancy." [1]

Of the depth of maternal impulses Helene Deutsch says, "Despite this variation in reactions to identical social influences and despite similarities of reaction under different cultural conditions, some emotional relationships between mother and child are so deep and primitive that they transcend all social and individual differences."[2]

However, the capacity for mothering does not appear spontaneously in the personality of a young woman when her first child is born. It begins to develop in the mother's own infancy and continues to be elaborated and further integrated in the mother's personality with her experience in bearing, nurturing, and educating each of her children. A woman's maternal responses to successive children tend to have qualities engendered by earlier pregnancies and her relationships with her older children. Therese Benedek puts it this way: ". . . motherliness is a function of a specific—biological and psychic—maturation; its completion, as many observations prove, is only rarely reached at and about the birth of the first child."[1]

There are many reasons for wanting a child. One of the strongest is that reproduction, a function of which only women are capable, is the biological evidence of completeness in a woman.

Physiologically and anatomically, the relationship of a mother to the child growing within her uterus is a very close one. Emotionally also, the mother and her child are extremely close. The mother's feelings vary from day to day with what is happening in her environment but over the months of pregnancy become quite intense. The baby is not just a baby growing within the mother. The pregnant woman is not a mother *and* child, but a mother-child, a whole being.

Then comes the day of delivery when many adjustments have to be made by both mother and child. The baby which was truly a part of the mother's body now becomes a separate entity biologically, doing his own breathing and eating. However, the baby still has tremendous needs for the mother and so has the mother for the baby. These two persons are still biologically mutually dependent; the child needs to be fed by the mother and the mother's organism is preparing for lactation. If the mother nurses the baby, her uterus contracts and returns to normal size much quicker than if she does not nurse. In primiparas the milk comes in around the fourth or fifth day while in multiparas the milk is available earlier, on the second or third day after the baby's birth. Thus, the mother seems to mature physiologically as well as psychologically during her first pregnancy and mothering experience.

Many mothers speak of the greater efficiency of their bodies from one normal pregnancy to another. A mother of four children had severe nausea in her first pregnancy and during the last trimester had persistent edema in her legs and feet and recurrent abdominal discomfort. The periods of nausea decreased in each subsequent pregnancy until in the fourth pregnancy she did not report any nausea at all. The edema had also lessened in each pregnancy and by the fourth she experienced some back pain, but she was not aware of abdominal discomfort as she had been in her earlier pregnancies.

Good prenatal care should help young mothers gain confidence in themselves, mature more rapidly, and probably aid the pregnant woman not only psychologically but also physiologically.

Although this is especially important in first pregnancies, mothers can gain benefit from adequate supervision in all pregnancies because of the fact that each pregnancy is another new experience for the mother.

Early Roots of Motherliness

Developing motherliness represents a gradual transition from being the dependent one, protected and nurtured by a cherishing mother, through the increasingly active and autonomous stages of being a girl child and then an adolescent, to becoming the giving and nurturing person. By the second half of the first year of a mother-child relationship when the sense of separation is beginning to develop in the child, the child begins in a fragmentary way to take the active position in the relationship, initiates contact with the the mother's body, elicits her attention through his babbling, and even begins giving, by bringing his toast to her mouth or by gestures of affection.

As the child becomes a toddler and his perception of separation becomes sharpened, he seems to develop his sense of individual autonomy by exploring both halves of the mother-child relationship, imitating his mother's actions as a means of channeling his energies and at the same time claiming a baby's prerogatives of being given to, loved, and protected. Thus, early roots of motherliness, in men as well as in women, sprout from the gradual evolvement of the active-passive, giving-receiving, submission-resistance aspects of the mother-child relationship. Yet even at the toddler stage there is a deeper intensity in the mothering activities of girls than boys. Girls tend to handle dolls more gently and to become more intent in such activities as wrapping a doll in a diaper. However, at 3 a child of either sex readily slips from one role of the relationship to the other—

for example sitting in a rocking chair nestling a doll and holding a bottle to the doll's mouth and in the next moment rocking himself and sucking the bottle greedily.

The care with which 3-year-olds participate in dramatic play is an indication of their absorption in both roles of the mother-child relationship. The different ways they play the mother role reflect real differences in mothers' personalities. Betsy may be tender and self-effacing, conforming to the demands of the doll baby as she sees them and creating an imaginary daddy whose wishes she serves in the same giving manner. Joan may be confident and efficient with an air of "mother knows best," giving pleasure with generous abandon. Elsa may be bossy and at times aggressively punitive, but at other times passionately affectionate.

At 5 years of age Betsy felt her love for her daddy as a longing to be the mother while he was the father. In doll play she turned the mother doll into one of the babies to whom she gave tender care while she became the mother sitting opposite the daddy at table.

Anne at 10 teasingly refused to share the peanuts her mother had given her with some smaller children. In response to the comment, "I thought you were the girl who was growing up to be a mother," she laughingly said, "I am, but I'm not a mother yet." Yet when she was alone with the children she lined them up and dealt out her peanuts one by one until she had none left.

Self-Doubt

Even though becoming a mother is a fulfillment of the deepest needs of a woman's nature, and she brings to it the accumulated understanding and feelings of all of her previous experience, the days after the birth of the first child are for all women filled with new experiences that make great demands on their resources.

The reaction, "postpartum blues," occurs so commonly in the first days of being a mother that there is not a great deal of attention paid to it, but it is easily recognized by doctors and nurses who care for women after childbirth. Some obstetricians refer to this phenomenon as "the third-day blues." Even in the first weeks after the mother goes home from the hospital, crying spells are not uncommon. Often, it is only after a mother is sure that her baby can depend on her and that she is a dependable competent mother, a complete woman, that the postpartum blues disappear. New mothers who become depressed and anxious often feel as though they should not be feeling that way.

Self-doubt is old in the development of a young woman's personality. When little girls are first aware of the difference between male and female they may wonder if they are incomplete or somehow inferior to boys because boys have a penis and girls do not. An older woman, when babysitting, answered a 3-year-old girl's question about this by saying, "Carol, boys are fancy on the outside and girls are fancy on the inside." But for a little girl inside "fanciness" which cannot be seen is hard to understand.

The hope of becoming a mother herself someday, of having significance comparable to her mother's in relation not only to children but also to a man like her father, is one of the deepest motives in a little girl's growing up and in her dealing with feelings of uncertainty about whether girls are less complete or of less value than boys. Feelings of self-doubt are not dealt with once and for all in early childhood but tend to recur with special poignance at times of striving to attain new aspects of a feminine identity.

An illustration of this process has been aptly provided by 9-year-old Anne, whose favorite outfit for some time was an old pair of dungarees and a shirt borrowed from her younger brother's drawer. One evening Anne said angrily to a neighbor, "Sometimes I wish I was a boy." When asked why she felt that way she replied vaguely, "Oh, because boys can go huntin' and fishin' and stuff." Hunting and fishing were the special activities the boy next door shared with his father. In response to the comment, "But only girls can grow up to be mothers" she replied with a toss of her head, "I don't care." And to the second comment, "And only girls can grow up to have husbands the way your mother has your daddy" she again replied, "I don't care."

But the next day Anne came again to her neighbor's door, her little brother trailing after her. This time she stood wearing a starched dress, white socks, and black patent-leather shoes, her hair carefully combed. In her arms was a doll almost as big as a baby. She pulled back the blanket and said, "I wanta show you my baby." Pointing out that the doll had on a real baby's dress she said, "My mom gave me that. It was *my* dress when I was a little baby." When asked whether her baby was a boy or girl she replied, "I don't know, it could be either." But when reminded that this couldn't be, that babies are either boys or girls, she said, "It's a b—, no it's a girl." Her little brother put in at this point, "When I grow up I'm going to have a little baby like Aunt Ruth's," and Anne said gently but firmly, "No, Benny, only girls can grow up to have babies."

Many concerns, worries, wonderments, and conflicts accompany all women during pregnancy. All prospective mothers have both positive and negative feelings. During pregnancy women have increased needs to be cared for and given to by others. Increased consideration and support from her husband add to a mother's satisfaction in pregnancy. One woman expressed this in reverse by telling of her discomfort in pregnancy, "You see I don't like to have to ask twice to have somebody get something from the top shelf for me. I'd rather they offered or that I could get it myself."

The Mother's Resources

A mother experiences the birth of the child as separation, as loss of oneness with the child, and has to strive for a sense of relationship and mutuality on the new basis of feeding and giving care.

One aspect of the preparation of a mother's body for lactation is that the hormonal balance is such as to make the mother's own dependent needs insistent at the same time that she experiences the baby's dependence upon her.[1] As the mother achieves confidence in her ability to feed and care for her baby, her own dependent needs are a source of her intuitive responsiveness to the baby's needs. Through feeding and caring for her baby she derives fulfillment for her own need to experience being given to by another.

Gradually as the milk comes in well and the baby wakes up and begins to nurse satisfactorily, both mother and baby gain in confidence in each other. This is true, also, of the mother who bottle-feeds her baby, though there may not be identically the same skin-to-skin contacts. Important above all, we believe, is the growing trust and confidence that come to the mother and baby in the feeling "I can feed him" and "she will be able to take care of me."

A father's visits are of great importance in the mother's development of her capacities to care for the child. Moreover, the father also, to develop his fatherliness, needs to experience a sense of relationship to the mother and child and a feeling of their need for him. The preservation of the meaning of the family relationships is the purpose of the rooming-in technique in maternity wards.

Nursing care that is giving and supportive to the mother may be a very important aspect of the mother's capacity to nurse her baby and to care for his needs in other ways. Professional persons with deep maternal feelings in their own personalities often find gratification in caring for other people's babies, but these maternal impulses can also be gratified through caring for mothers and identifying with their maternal satisfactions.

In discussing the tendency of women to develop their capacities as mothers through their experience of motherhood, Therese Benedek says that the mother's resources are not only replenished by the fulfillment she receives from her husband, her mother, and other supportive people around her, but that "on a deeper level of her personality, her emotional needs are turned toward her infant for satisfaction . . . the newborn . . . feeds back to the mother in emotional gratification what he receives in food and care. This capacity of the mother to receive from the child, her ability to be continuously gratified by this exchange, and to use this gratification unconsciously in her emotional maturation is the specific quality of motherliness. It evolves along with those processes by which the girl develops from a passive receptive individual to an active adult woman."[3]

Differences in Resources

But the resources of mothers differ—resources developed within themselves and external resources in their relationships with the people around them. A mother who has never been held close and comforted by a loving mother-person has not the basic sources from which to convert gradually the need to be given to, to the fulfillment of giving.

When Mary's mother was born, Mary's grandmother was angry with her husband and cared for his child with an attitude of resignation; Mary's mother has always felt guilty about being dependent on anyone and tends to deny that she needs any help. When Mary was born, her mother felt almost overwhelmed by the combination of Mary's dependence and her own unsatisfied dependent needs and marshaled all of her active energies to defend herself against the combination. She went out a great deal, undertook responsibilities outside her home, and fed Mary with determined force. Mary reacted by taking very little of her formula and never responding eagerly to her mother's care. She ate better when she could feed herself, found pleasure in the active use of her body, but continued to be on guard against intimate body contact with anyone.

As Mary has grown she has had a persistent preference for foods that can be bitten and chewed rather than liquids. Foods other children tend to enjoy sucking, Mary bites up and swallows quickly. She is often concerned about the possibility of eating something poisonous. She has deep feelings about little animals or any creature that seems helpless, seeming to understand them intuitively. She teases them when she is angry with herself but she is also concerned with creating a "new deal" for helpless creatures. For example, she has talked about possessing a deep secluded woods where all of the little game animals can hide from hunters.

At the age of 8, Mary is now talking about having a husband and becoming a mother. One wonders what her resources will be for this experience when she is grown. Will she have had enough supplementary experience in being cherished by the time she is an adult to be able to accomplish a modification of the image of mothering passed down in her family?

David Levy found women who were constitutionally maternal to a high degree to be influenced both by current circumstances and childhood experiences in a way that made their behavior with their children less appropriate than it might have been had their own needs been more fully gratified.[4] Jackson, Klatskin, and Wilkin have reported that the basis for the divergence in attitude of a number of mothers studied by them "is to be found in their own background of experience and interpersonal relationships."[5]

Babies are often born to mothers so young that motherhood is overlaid on the needs and wishes of adolescence. Such young persons are not yet likely to have developed a stable sense of self, are often in intense conflict between the wish to grow up and the wish to hold on to the security of childhood dependence and freedom from responsibility. Consequently, they do not have a firm base on which to develop their motherliness. Then, too, very young mothers seldom have mature husbands to give them the support they need if they are to develop their capacities for mothering and to complete the growth tasks of adolescence.

Such young parents tend to respond well to relationships with professional people who understand them as they are and who can generously support the growth processes within them. Their adolescent strivings often make supportive help from their parents unacceptable, but they can reach out to motherly women for help. The young mother may even behave a little like an affectionate and reliable sitter to her own baby, absorbing from the woman next door or from a professional worker the resources for carrying out her responsibilities.

In some subcultures in this country an adolescent mother is often welcomed into her mother's home after confinement. For both mother and daughter it is natural that the mother should continue to be the head of the house, and the daughter is in a very real sense like a babysitter.

Identification with a more mature, motherly person is often supportive to the development of young mothers. On the other hand, fears of inadequacy are easily engendered in them by the competence of an experienced person who takes over the care of the child. One frightened, immature young mother broke off her relationship with a public-health nurse after the nurse gave a demonstration of bathing the baby; but because the nurse understood her feelings, she was later able to resume the contact. This young woman developed a great deal in her relationship with her child through the support the nurse persistently gave her, permitting her to do the giving to the child.

Some very competent young mothers may also tend to become anxious whenever it is necessary for others to take the initiative in caring for their babies. This is often the source of stress between mothers and nurses on the maternity floors of our modern hospitals. What is to the nurse good nursing practice may be experienced by such a motherly young woman as an intrusion upon her relationship with her child, disturbing to the deeply satisfying mutuality.

Professional people are, in the most constructive sense, an extension of the range of the external resources available to mothers as support in developing their inner capacities for mothering their children and fulfilling their own life tendencies. The recognition of development as characteristic of motherhood creates a new role concept for professional workers who have relationships with mothers.

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The pediatrician's role in a clinic's experiment in providing . . .

TEAMWORK IN HELPING FAMILIES TO LAUNCH A LIFE

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THREE artificial separations complicate most efforts to provide health services to child-bearing and child-rearing families. These are:

1. The schism between obstetrics and pediatrics, resulting in the care of the mother being separated from the care of the child.

2. The consideration of the mother or child apart from the father and total family.

3. The separate functioning of the many professions which have something to contribute to total family health.

During the years 1950 to 1956 a clinic known as the Family Health Clinic at the Boston Lying-In Hospital attempted to find out how these artificial separations might be minimized. This clinic was supported in major part by a grant from the Association for the Aid of Crippled Children. Members of the regular staff of the department of maternal and child health of the Harvard School of Public Health, and of the Boston Lying-In Hospital, took part in the experiment. Analyses and preparation of the accumulated data were made possible by special grants from the Charles H. Hood Dairy Foundation of Boston, and the Milton Fund, Harvard University.

This paper will review some elements and implications of the pediatric experience.

The clinic was organized under sponsorship of the department of maternal and child health of the Harvard School of Public Health, the Boston Lying-In Hospital, and the Children's Medical Center of Boston, as a pilot study to explore the use of a multiprofessional approach in a single obstetric-pediatric clinic.[1 2 3] Patients were selected from the hospital's regular outpatient clinic, criteria being that they be primiparous married women, free of unknown pathology, and living within accessible distance of the service. The clinic was open to mothers, fathers, and children, and offered family-focused service throughout the entire period of pregnancy, and for at least a year afterward.

Over the period of 6 years prenatal, postnatal, and well-child health supervision was supplied to 116 families having their first babies and 25 of the same families during subsequent pregnancies.

Clinic Operation

The Staff. The clinic team gave service of the various kinds pertinent to present-day maternal and child care. Obstetricians, pediatricians, nurses, nutritionists, and social workers provided direct service to patients and consultation to each other. A psychiatrist served as mental-health consultant to the rest of the team.

Based on a paper presented at the 1958 meeting of the American Public Health Association.

Method. Prenatal services began early in pregnancy for the majority of patients. Pediatric-clinic visits began when the baby was about one month old, and proceeded at monthly intervals during the first year. Both obstetric and pediatric services were provided with considerable flexibility and frequency, varying with the disciplines involved and with needs of individual families. As far as possible, families were cared for by the same personnel throughout their experience in the clinic. However, the pediatrician started initial contacts with the families as a member of the prenatal service team.

Usually the patients were seen in each visit by 3 or 4 staff members who assembled their observations into one record. Teamwork was facilitated by pre- and post-clinic case conferences of total staff, by casual or planned individual conferences between staff members, by administrative staff conferences, and by additional case conferences with the mental-health consultant.

Premises of Operation. The obstetric and pediatric care was given on the premises that:

1. Pregnancy, child bearing, and child rearing comprise a continuum.

2. These natural processes tend to intensify the problems of daily existence and to introduce new problems posing challenges that can literally make or break a family.

3. The way in which each new challenge is met has immediate and long-range effect. Mastery tends to move the family on to further success, whereas failure tends to move the family in the opposite direction.

4. Logical services consist of timely measures enabling families to master the crises of pregnancy and child rearing and in doing so not only to prevent complications but to derive strength from the experiences.

The project experimented with methods of providing these services as an integrated function of several professions working together.

Pediatrics In the Clinic

The clinic goal was to launch a life, and with that life new dimensions in the life of a family—not a 9 months' task, but one extending throughout childhood—a continuum without a real end point even at the elected time of ending well-child care.

It made an effort to seek out and utilize the powers of growth and development for the benefit of child and family—the fetal growth and development, the parental maturation that takes place during and after pregnancy, and the subsequent growth and development of the child.

The pediatricians were participants from the beginning of the prenatal period onward. They tried to get acquainted with the parents during the pregnancy and to be of informational assistance and a source of relaxation and comfort by stressing that the parents would have their continued support after the child arrived. After the child was born, they proceeded with standard child-health supervision practices, with every phase of care geared to the growing and developing parents as well as to the growing and developing child. They used the usual tools of well-child supervision to avert death, prevent disease, and prevent distorted parent-child relationships. They stressed promotion of child and family health by channeling services through the parents as well as the child.

The pediatricians made steady, systematic search for parental strengths and tried to help parents become aware of those strengths, pointing out to them in visit after visit actual evidence of how they themselves were growing, developing, and functioning in their parenthood. Parents were helped to understand how the quality of parenthood gradually develops through interaction between themselves and the child and between themselves as husband and wife becoming also father and mother.

In Loco Parentis. As is so often the case today, the parents served lacked the supports that an extended family provides. Many were far from their own parents, and most grew up in small families where they had had little experience with child bearing and child care before they entered these adventures themselves. Many were very young. The family aspects of the Family Health Clinic were thus important in the sense of the staff's working with the whole family, and also in that the clinic itself served as a sort of "family" for the patients.

Protection of Parents. Advice on child care, especially in the newborn period, was kept simple. A conscious effort was made to strip daily routines of nonessential practices that might confuse, fatigue, or even overwhelm inexperienced parents. New routines of care were introduced gradually and were adapted to the parents' confidence and competence to carry them out.

Specific recommendations were made for maternal rest and for parental recreation. The fact that few parents included recreation in their planning seemed closely related to a paradoxical time-outlook many of them manifested. While they tended to regard the baby and the demands of parenthood as an immediate crisis calling for an all-out effort on their part even to the exclusion of physical rest, recreation, and adult companionship, at the same time they looked on babyhood as an interminable and demanding period of dependence. The clinic's pediatricians attempted to free them from such unrealities by gearing child-care advice to simple essentials and helping them set a comfortable pace that they could have some hope of maintaining throughout their child's growing and changing childhood. In these efforts the pediatricians attempted to convey *the sense of the moment* and *the sense of motion.*

The Sense of the Moment. At each clinic session the pediatricians elucidated the transitory phenomena of infancy, using every opportunity in the examination, in the interview, and in anticipatory guidance to present the brief, lovely moments of infancy and early childhood. This was done because many developmental phases last only a few days yet are momentous milestones and should be made visible to nurturing parents so that they can find enjoyment and encouragement in them as does a gardener with the first spring crocus. The purpose was to help the parents to become progressively perceptive and increasingly aware of the child as a separate and unique individual. Thus, the child would be encouraged to become increasingly independent and the parents to become less dependent on the clinic.

The Sense of Motion. In striving to convey the sense of motion, the pediatricians during the physical examinations, history taking, and anticipatory guidance always linked the immediate visit with the preceding month and the month to come, so that the parents could perceive the dynamics of the baby's progress and their own development. The clinic record was employed as a tool of parental development. Notes made of parental comments and their concerns of the moment were judiciously used at subsequent visits to illustrate progress.

Fathers. Fathers were not in the clinic as much as the staff might have wished, since the hours conflicted with most of the fathers' working hours. However, such paternal attendance as did occur convinced the clinic group of the desirability of arranging services to encourage father participation.

The clinic staff saw the father's role as the stabilizing, nurturing head of the family.[4] [5] This view was supported by the fathers' responses when the examination of a child was conducted in the presence of both parents and with their collaboration. Time and again paternal cooperation proved a facilitating force in the growth of family strengths and unity. Conversely, in some situations in which fathers were unable to come to the clinic, well-meaning wives used the clinic as a threat to bring the husband to their own way of thinking, thus converting the potentially unifying influence of the clinic into a source of family conflict.

Siblings and Other Relatives. Additional pediatric values were inherent in the fact that in many instances the clinic served more than one child in the same family. There was not only a salutary carry-over from pregnancy to pregnancy and child to child, but also benefits derived from seeing brothers and sisters at the same time. For example, in helping a family simplify child-care practices, it was better to plan for the family as a whole than to drift into prescriptions of overelaborate attention to one child. In helping families whose children had behavior problems and in which emotional interrelationships were strained, the fact of knowing the various members personally helped the pediatricians to custom-fit their counsel.

The overall family approach included consideration of the influence of a number of relatives—the babies' grandparents, aunts, and uncles. Sometimes these were members of the household, or neighbors. Often they lived far away, but entered the family scene in visits of momentous influence. Clinic experiences indicated that the family's relationships with these relatives were almost never neutral, and that whether they turned out to be of a strengthening or destructive nature could be influenced considerably by the clinic.

Shared Perceptions

In parent-focused pediatrics, the better the pediatrician comprehends the parents the better work he can do. In this clinic, the pediatricians' comprehension was facilitated by getting to know the parents during the prenatal period, by working with the whole family, and by knowing its members not only through pediatric contacts but through the selective perceptions of various colleagues of other disciplines. Case conferences provided the pediatricians with additional information on family progress from other workers and with an opportunity to convey their own findings to their other colleagues for use in further parental support.

Analysis of clinic records reveals that individual staff members gained quite different impressions of the parents, and that the pooled impressions were often different from any of the single ones. The nature of the impressions seemed to be molded by the interpersonal relationships between the patients and the staff members and to be influenced and altered by numerous other factors: the staff members' professional discipline; the sex of the worker; the personalities of workers and patients; and what and how much the workers and the patients had in common.

The patients seemed to make their own distinctions in the kinds of material suitable for presentation to one worker or another. For example, they might talk freely with the social worker about financial hardship but not even mention the subject to another worker, or they might tell the pediatrician about their fear of a possible congenital anomaly without mentioning this fear to anyone else. The pooled perceptions gave the pediatricians many clues concerning subsequent developments in child care in specific families and as time went on impressed them with the inestimable value of such predictive "previews." They found that they could start work with a newborn child already better acquainted with that child and his family than they could ordinarily hope to become within several months' time in separate practice.

Case analyses indicate that these shared prenatal observations gave the pediatricians from 6 to 40 pertinent clues per family. Families were identified who could best make use of a structured, highly scheduled type of infant care, as were families who were likely to do better on a more relaxed regime taking their cues from their child from day to day.

In addition to these positive possibilities, the team's shared insights provided danger signals varying from useful clues to impending minor pediatric predicaments to warnings of potentially serious family strain to which a pediatrician might otherwise have unwittingly added.

Values of Teamwork

Every staff participant in the clinic undoubtedly benefited from the privilege of working with other professional disciplines and with medical colleagues of various specialties, but the pediatricians seemed unusually favored. In the first place, pediatrics shares to a high degree the specific concerns of each of the disciplines and specialties which were represented on the team. Like the nutritionist, a pediatrician is characteristically concerned with feeding. In working on a team with a nutritionist, the pediatricians had an opportunity to increase their competence in advising on feeding practices. One happy aspect of this collaboration was the development of feeding practices geared to stages of children's motor, social, and adaptive development.

The teamwork between the pediatricians and the team's nurses was established with relative ease because of their traditional pattern of working together. The effects of their relaxed attitudes were noticeable in conversations in which they examined their former practices with new viewpoints.

Pediatric benefits from association with the social workers can best be likened to "depth perceptions." Through the social workers' explorations and understanding of the patients' situations, the pediatricians could better comprehend the place each child occupied within his family. Such comprehension is always a prerequisite to pediatric diagnosis and planning, but generally one which the pediatrician has to manage to get as best he can through his own data gathering and insight. With the privilege of social-work collaboration, the pediatricians not only had a wealth of data at their fingertips but had benefits of the kind of perception and interpretation made possible by social-work training.

As always, the representatives of each discipline saw a situation through the eyes of its own profession and pulled out data which might not have been visible to or impressed an observer of a different orientation. This enabled fellow workers to view their own findings in a different light.

For instance, in the course of maternal interviews the nutritionist often became aware of the mother's attitudes toward her own diet—attitudes which frequently affect the way a mother feeds her child—and could let the pediatrician know and thus be able to reckon with influences which might distort specific infant-feeding practices. Thus, pediatricians were alerted when a mother known to have restricted her own diet to a monotonous range of foods seemed reluctant to introduce new foods, tastes, and textures to her baby.

The pediatricians were continually impressed with the pediatric good that nonpediatric workers accomplished when these workers added a few pediatric insights to their own skills. For instance, in interpreting infants' feeding behavior the nutritionist made wise use of an increasing understanding of child-development patterns. At the same time, the pediatricians recognized steady improvement in their own work as they gradually incorporated new points of view and methods acquired unconsciously by working with colleagues of several disciplines. Their interviews with parents, for example, were considerably affected by an awareness, consistently stimulated by the mental-health consultant and the social workers, of the stresses the parents were experiencing.

Staff members of the three medical specialties represented in the project—obstetrics, pediatrics, and psychiatry—found in working together that they could do their own tasks better because of something gleaned from their colleagues' contacts with the patient. As the project went on, each became aware that in addition to giving them the advantages of being with other professions the clinic was providing them with an unusually pleasant form of postgraduate medical education.

The values of the pediatricians' working with the obstetricians have been mentioned in terms of the unification of the obstetric-pediatric continuum. Another type of unity also occurred. In a partnership composed solely of obstetricians and pediatricians conspicuous differences between the two specialties might stand out. However, in this experiment, in which both groups worked with many other professions, they found themselves strongly allied by virtue of their shared common medical background. Time and again they interpreted and reinforced each other's clinical roles to other members of the staff. The act of serving each other in this regard seemed to diminish the differences in viewpoint between these medical specialties. The same situation held true between these physicians and their other medical colleague, the mental-health consultant.

The psychiatric consultant was thoroughly versed in the chief attributes of normal family mental health, and so able to direct the team's attention to the many healthy phenomena appearing from the prenatal period onward. While they were alert to signs of incipient trouble, their principal contribution was an awareness of signs of strength. In a review of the cases one is struck by how astutely the psychiatrist identified strengths in the parents in the majority of cases and guided the rest of the staff in the judicious nurture of those strengths.

Perhaps the major obstacle overcome in this multidisciplinary project was the gradual effacement of some of the stereotypes that representatives of the various disciplines have of one another. For example, the physicians had opportunity to see at first hand how social caseworkers use techniques of "ego support, clarification, and modification of environment," as well as educational methods.[6] The social workers, for their part, saw that pediatrics is not limited to advice on the mechanics of child care, but shares social work's concern with the reinforcement of family capacities to cope with stress. All the disciplines became aware that each profession has ethical standards respecting patients' privacy.

The consensus of the participants as the project ended was that the clinic's advantages were greater than its problems. The majority of the latter had to do with the development of methods required by a multidisciplinary group learning to work together and with whole families, and could largely be met by administrative provisions.

Pertinence to Public Health

A clinic of this sort might be a helpful adjunct to a public maternal and child-health program as an excellent service to a group of families, and as a means of raising standards of care in the rest of the program and perhaps elsewhere. Possibilities would depend on how much the participants function elsewhere, and how much the project could be used for preservice and inservice training.

One of the most important features is the carryover of insights gained in the experience into the participants' other functions, for the participants undergo personal and professional maturation which makes itself manifest in more effective functioning wherever they are.

As for carryover of method into another setting, this could be as little or as much as the other setting permitted. It could vary from a single improvement such as record linkage making the mothers' prenatal and obstetrical records available in the child-health work, up to a full-scale duplication of the clinic's total approach.

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MASS PRESCHOOL VISION SCREENING

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FOR MANY YEARS the maternal and child-health division of the Michigan Department of Health has been concerned about the great number of children who reach school age with an eye difficulty which could have been prevented by early detection and treatment. These children show no signs of vision difficulty. Because their eyes look normal, their parents are surprised to learn that one eye has little usable vision and that in most cases the condition cannot be adequately corrected.

Again and again, eye specialists have reported to the department the disappointing experience of having school children referred to them with the condition beyond repair, as it usually becomes fixed at about the age a child enters school. It is called amblyopia ex anopsia.

When two eyes are of different strengths or for any other reason do not cooperate adequately, a clear picture is not obtained when both eyes are used. As a result, a child with this difficulty uses only one eye, and central vision, or the ability to see small things, does not develop properly in his other eye. The longer this goes on the less chance there is for him to develop normal vision.

When such a child is 6 or 7 years of age vision in the weak eye can sometimes be restored to normal. Even at this age, however, remedial treatment is a long, tedious, and expensive process. The doctor knows that if he had seen the child at 3 or 4 years of age the chance of successful treatment would have been greatly increased.

Although amblyopia ex anopsia is often well established by the time a child is 3 or 4 years old, the condition is then by no means hopeless. In some cases all that is needed is a proper refraction which makes it possible for the two eyes to work together. Sometimes it is necessary to cover the stronger eye for a short period of time in order to force the weaker eye to learn to see. No matter what the treatment, it is usually relatively simple and comparatively inexpensive at this age. Because uncorrectable visual loss can usually be prevented if the condition is found in its early stages, early case finding is of utmost importance.

Over the years various organizations and practicing ophthalmologists in Michigan have started screening programs in an attempt to find preschool children with this condition. However, because of the limited number of professional personnel available to organize programs and to train and supervise volunteers to do the screening, they have reached only a few hundred children. In Michigan there are 400,000 children in this age bracket.

The Beginnings

Within the State health department there had been some discussion of the need for programs to find children with this condition, but no definite steps had been taken to organize mass-screening programs until December 1957. At that time the chief of the department's vision section spoke to the parent-teachers' association in a Macomb County school as the guest of a parent who was the administrative assistant of the local health department. In the following question period a parent asked about amblyopia ex anopsia. This provoked a discussion of the problem of early case finding and the need to try out some new techniques of organization and screening. Before the evening was over an informal committee meeting had been held with representatives of the health department, the school, and the local PTA to lay groundwork for such a project to be run in cooperation with the State health department.

At almost the same time the State health department received a letter from the Grand Traverse

County Health Department. The local Lions Club, at the instigation of a local ophthalmologist, was asking for help in starting a preschool vision screening program. The State vision consultant met with the county health department and the Lions Club, and suggested the organization of a countywide program in contrast to the school-centered program being developed in Macomb County. As a result, two projects which were basically the same but had slightly different organizational patterns were in the planning stages.

Guide Lines

Following these local meetings, the Advisory Committee of Ophthalmologists of the Michigan State Medical Society met with the vision staff of the State health department and recommended that an attempt be made to reach a larger percentage of preschool children than had been reached in previous programs, and to strive for better techniques of screening.

The group set up guide lines referring to age levels, eye efficiency, and qualifications of screening technicians.

Its recommendations were:

1. Any child past his third birthday at the time of the screening could be included.
2. The ability to see four out of six 20/40 symbols with each eye individually and with both eyes together would be required for passing the test.
3. Screening would be done by technicians who were certified by the Michigan Department of Health, which trains and certifies technicians in cooperation with teacher-training institutes.

Recognizing the responsibility which local health departments assume in asking parents to visit doctors, the group recommended this standardized procedure so that local health departments would feel justified in following up children referred to their physicians for treatment. In order to save time, the committee recommended that in each project a local certified technician who had already been trained by the State health department for screening school-age children be employed to do the screening.

One of the major problems in conducting previous projects of this kind had been that the child did not know in advance what to expect or what was expected of him. When he arrived he found he had to adjust to strangers, learn a new technique, and establish a method of telling what he saw. He could not be hurried and was frequently unable to cope with all of these new problems. He often was apprehensive, if not downright fearful. In order to eliminate as many of these factors as possible, the group decided to experiment with a new screening device which would make it easier for the child to communicate with the technician.

A chart was prepared with a large picture of a rabbit at the right and a flower at the left. Six 20/40 E's (a size normally distinguished 40 feet away) were mounted on a wheel behind the chart so that by turning the wheel the E's would appear individually in an aperture in the center. The child could then indicate the direction in which the E was pointing by referring to the rabbit, flower, sky, or ground.

Miniature reproductions of the chart were made which could be sent to the children's homes prior to the screening. Instructions were included telling parents how to use the chart to play a game called "The Table That Points." The suggestion was made that the parents hold short practice periods by playing this game with their child each day so that the child would become familiar with the E and learn to tell the direction in which it pointed.

Local Planning

Local planning was a major factor in the development of the projects. In both areas, in addition to the local and State health departments and the

Volunteer receptionists in a Michigan vision-screening project check each child against the appointment list and make a record of his eye history by interviewing his escort.

voluntary agencies, the boards of education, Lions Clubs, and local doctors joined in the planning. A member of the staff of the local health department was the coordinator of each project and participated in all planning sessions. The local health department provided certified vision technicians to do the screening, who were paid by the local Lions Clubs. The department handled the publicity, consisting of newspaper articles, pictures, radio scripts, television programs, and slides for television spot announcements, most of which had been prepared by the State health department. A representative of the county health department and the State vision consultant met with local doctors to secure any suggestions they might have.

In both areas voluntary agencies assumed the responsibility for underwriting the mailing costs, securing lists of children prepared by the office of the county superintendent of schools, addressing letters, making appointments, telephoning, acting as receptionists and helpers at the time of the screening and rescreening. In the Macomb County project these functions were carried out by the PTA of the school involved, and in Grand Traverse County by the local Lions Club. Members were assisted by their wives.

The vision staff of the State health department helped in planning, setting up, and supervising the projects and prepared publicity materials with the assistance of the department's section of education. The timing of all aspects of the projects was directed by the State health department.

About 4 weeks before the actual screening tests, letters telling about the program were sent to families having preschool children 3 years of age or over. Enclosed in each letter was a card to be returned if they wished an appointment. In the PTA project telephone calls were made to those parents who did not reply to inquire if they might have forgotten to mail the card. This was not done in Grand Traverse County. The greater participation in the project in Macomb County is attributed largely to these calls.

After cards were in, the scheduling was started. It was handled mainly by one or two persons from the voluntary agency. These were women who could devote several hours each day entirely to the project. In one program, appointments were set up at the rate of six each 20 minutes, and in the other seven every half hour. The programs ran each day from 9 a.m. to 3:30 p.m. The schedule allowed the technicians a short break in both morning and afternoon. With the assistance of several volunteers from the sponsoring agency, appointment cards were sent out and with them the home-teaching card with directions for its use.

In Macomb County an eye history for each child was taken by the receptionist at the time of the screening. In Grand Traverse County the same questionnaire used in Macomb County was sent home with the appointment card and returned at the time of the screening.

The Children

Few children were unprepared when they came to be screened. If a child was not prone to cooperate or seemed not to understand, the technician advised the parent to take him to another room to play the game for a little while and then return. If this did not produce the desired change effect, the parent was given a new home-teaching device and requested to make another appointment at the time of a retest at a later date. The parent was urged to play the game with the child for a short period each day to familiarize the child with the procedure.

Even with a second try, a small percentage of the children (4 percent in one project and 7 percent in the other) could not be screened. The larger percentage was in Grand Traverse County where a dental clinic was operating in the same building as the project. Occasionally, children in the vision-screening project would catch a glimpse of a dentist wearing a white coat. Every time this happened the children who saw the dentist seemed more apprehensive and were more difficult to test than the other children.

In screening older children the State health department advises against allowing them to watch as others are screened. However, since children of preschool age would be unlikely to be aware of the other children's ability to "pass" the test or to "memorize" the order in which the E's were presented, each child was allowed to watch one or two others take the test. This seemed to give the children a sense of security. They seemed to notice only that it did not hurt and was fun. It was also found advisable to have the parents present. A few had to be asked not to tell the child the answers, but in most cases a parent's presence helped rather than hindered the testing.

A time study indicated that the children whose parents had helped them with the game for a few minutes each day for several days were on the whole better prepared than the others and, with a few exceptions, were able to go through the test quickly, whereas children who had had little or no training took more time and required more direction.

A trained technician (right) in a mass-screening project for preschool children tests a child's visual acuity as a volunteer (center) turns the wheel that makes the E on the chart point to the rabbit, flower, ground, or sky.

If a child was unable to pass the test, parents were asked to bring him back for rescreening. In Grand Traverse County appointments were made for rescreening at the time of the first screening, while in Mount Clemens the parents were sent letters assigning them an appointment time.

The Team

It is an art to get responses from a preschool child even though he is well prepared. All kinds of schemes for helping in this had been set up, but a vital factor was the basic ability of the screening technician to work with children, to impart confidence, and to understand their moods. The technicians' ability, emanating from training and previous experience, resulted in satisfactory responses being achieved from most children with little effort, and in the completion of most tests in 3 minutes. Highly skilled as they were, the vision technicians, who had screened thousands of school children, showed some signs of insecurity during the first day or two of testing these small children. Soon, however, they were handling each child with confidence and could almost instantaneously gain his cooperation.

The volunteers, who acted as hostesses and helpers at the time of the screening and rescreening, contributed a minimum of a half day each. Usually, the technician and three volunteers—1 receptionist, 1 helper, and 1 runner, to get the next child ready while one was being screened—made a satisfactory team. If more volunteers were present than could be kept busy, too much talking and visiting together and occasional well-meant but ill-advised parent counseling occurred.

The State health department recommended that neither the vision technician nor the volunteer helper discuss a child's failure to pass the test with his parents. Therefore, either the local public-health nurse or the vision consultant from the State health department was present at the rescreening to talk to parents whose children failed the test or showed observable muscle imbalance.

During this interview a form for the doctor's report was given to the parent and a note made on the screening card as to his reaction. Parents who had listed symptoms in their child's eye history, such as occasionally crossed eyes or reddened lids, but who were not asked to bring their child for rescreening because he had no detectable visual loss, were visited or telephoned by the nurse as soon as possible to discuss the symptoms and suggest a visit to a doctor if this seemed advisable.

Outcome

The local health departments are now completing the projects by following up each referred case to determine if an examination was made and to gather data on the outcome of each referral. They will also help to get aid for families needing financial assistance, to secure the proper medical attention.

Following is a summary of the results of the two projects.

Macomb County (technician employed for 7 days):

383 families were notified.

321 families responded and were given appointments.

313 children were screened (8 children canceled appointments because of illness of the child or in the family).

256 passed first screening.

8 passed screening 1 week later.

6 who failed were not rescreened because of illness or because families were unable to make a second appointment.

11 failed the rescreening and were referred to their physicians for treatment.

13 showed some symptoms of eye-muscle imbalance, but no evidence of acuity loss, and were referred to their physicians.

14 could not be screened.

Grand Traverse County (technician employed for 9 days):

997 families were notified.

507 families responded and were given appointments.

452 children were screened.

390 passed first screening.

3 who failed were not rescreened because families were unable to come for second appointment.

15 failed the rescreening and were referred to their physicians.

13 showed some symptoms of eye-muscle imbalance, but no evidence of acuity loss, and were referred to their physicians.

31 could not be screened.

Nearly 50 percent of the families notified of the screening in the countywide project responded, in contrast to 80 percent in the school-district organization. Even 50 percent is a good-enough coverage to warrant effort to promote county organization in less populated areas during the summer months. This would make it possible for the vision staff to concentrate on school-centered programs in heavily populated areas during the school year. There is a strong possibility that as the programs prove themselves and children get care, parental cooperation will improve so that even a larger percentage of children will be reached.

Conclusion

The results of these projects show that mass vision screening for 3- and 4-year-old children is practical. In the two projects 94 percent of the children were screened satisfactorily. Of the 720 children to whom satisfactory tests were given, 3.6 percent could not pass and were referred to physicians. Of the 765 children who came to be screened, 3.3 percent showed symptoms warranting a followup by the nurse. Parent cooperation of 81.7 percent on the school-centered program and 45.3 percent on the countywide program indicates that parents can be stimulated to make use of a screening service if one is offered.

When a program is geared to determine if both eyes are functioning normally, not only can amblyopia ex anopsia be found in its early stages when treatment is most successful, but acute myopia, astigmatism, and extreme farsightedness can also be detected.

According to the doctors' reports which have so far been summarized, five of the children referred in these projects needed medical or surgical treatment. Two cases of already developed amblyopia ex anopsia were reported and 23 cases were found with refractive or muscular errors, many of which would have undoubtedly developed into amblyopia ex anopsia within the near future if left untreated. A complete report of the physicians' findings will be published at a later date.

The three new factors established by these experimental projects were:

1. Preparation at home greatly increases the number of children who can be screened successfully, as well as the speed at which they can be screened.

2. Up to 80 percent parental cooperation can be gained by setting up well-planned, well-staffed programs which are sufficiently advertised.

3. A carefully timed package program—including letters to parents, community publicity, and a delineation of the responsibilities of various agencies—prepared with the help of a local sponsoring agency can reach masses of preschool children.

A major requirement in such a program is to maintain standardized screening procedures by using a very limited number of technicians who have been certified after attending a rigid training course carried on by a State health department or a similar official agency. This agency must be willing not only to furnish the training but must assume the responsibility of giving the technicians continued and frequent supervision.

With such a plan, because a minimum of time would be required of local doctors and public agencies in order to provide the necessary leadership and guidance, successful screening projects could be carried on year after year in all communities throughout a State.

Man's only possession is time, and this is his only insofar as he uses it creatively.

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Meeting at three world conferences in Tokyo last summer, social workers considered ways of . . .

BREAKING THE CHAIN OF NEED BEGETTING NEED

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THE 20TH CENTURY will be chiefly remembered, Arnold Toynbee has suggested, as an age in which people first dared to think of the welfare of the whole human race as a practical objective.

The welfare of the whole human race was viewed from many angles in three international conferences held late last year in Tokyo.

Some 1,600 delegates from 42 countries, attending the Ninth International Conference of Social Work, saw the possibilities for advancing human welfare by making more planful links between economic and social programs.

The more than 500 representatives from 29 countries who attended the International Study Conference on Child Welfare sponsored by the International Union of Child Welfare underlined the importance of a family for every child—in whatever country he lives.

At the Ninth International Congress of Schools of Social Work, social workers from all over the world weighed the responsibilities and indeed even the definitions of social leadership in our age.

One of the most interesting aspects of these conferences was that out of this potpourri of social leaders from countries in every stage of development, came so much agreement on principles, even though differences do and must exist in regard to immediate ways of moving forward. There was, for example, a general recognition that all the problems of social progress with which the countries are struggling today arise from widespread acceptance of Toynbee's philosophical concept. As one report put it, "All societies today are standard conscious."

There was also clear recognition of the two interacting factors aggravating social problems in almost every country of the world today, though in widely varying degrees and with widely varying promise of alleviation: explosive population growth and poverty, widespread or in pockets surrounded by plenty.

The population explosion—resulting in part from the improved health practices that have come with the kind of perspective to which Toynbee alludes—is bringing the world some 30,000,000 additional people a year with the heaviest concentration on already densely populated Asia, where more than half the people of the world live today. Most of the countries of Asia are characterized by technologically underdeveloped agricultural economies. For them a rapid population increase means hunger and homeless people.

But even in highly developed countries with great natural resources, like the United States, the population explosion creates problems. Demographic patterns became skewed, creating large dependent groups of young and old for a decreasing proportion of working-age people to support. In countries in all stages of development a trend toward urbanization and a decline of opportunities for making a living from the land is drawing the population from the country to urban areas, often with grave consequences to family life. In all countries the heaviest effect of this mobility is on the teen-agers, whose behavior is influenced by a lack of stability and a loosening of traditional bonds.

In those few still underpopulated countries, such as Australia, the population increase is welcomed, but selected immigration dominates the planning and brings little relief to the countries with the greatest population problems.

People and Poverty

The consciousness of these pressures was most evident in the conference on social work, where, because of the setting, the problems of the underdeveloped countries, with few resources, absorbed the major portion of attention. There, with the conference theme "Mobilizing Human Resources To Meet Human Needs," the keynote speaker, Swedish economist Gunnar Myrdal spoke of "the international class gap" among countries as widening as living standards rise in rich countries and stagnate or fall in poor countries. Calling for new theoretical approaches, he maintained that the methods available to the developed countries for eliminating their pockets of poverty cannot be applied effectively everywhere—measures such as social-security laws cannot create absent resources.

This conference's commission on problems of growth and change in population structure, which defined the nature of population explosion and the differences in its effect on various countries, reported: "Some countries have adopted, among other measures, the technique of family planning as a matter of national policy in order to control the steep increase in numbers and to improve the subsistence standards of living of their overflowing masses. Some countries have adopted family planning as a part of their health services in order to improve family well-being. There is, however, no compulsion upon the individual citizen in any country to accept or practice such measures."

The conferees, however, tended to discuss the expanding populations as a potential source of strength to their countries—an economic resource for breaking through the circle of sickness, ignorance, and poverty, which could be tapped through recognition of the interdependence of social and economic measures.

This social-work conference, in fact, perhaps more than any in the past, looked squarely at the interdependence of economic and social goals. So strong was the emphasis on the interaction of social and economic factors that in suggesting priorities for social programs the conferees put first those programs which would contribute to economic improvement. They warned, however, that emphases on economic programs without consideration of human needs could not break the circle—that if people are to be in a condition to be productive they must be healthy and able to follow written instructions. A deficiency in the consumption of "food, shelter, and light after dark," they were reminded by Dr. Myrdal, affects the ability to improve health and education.

Children First

Where choices have to be made the conferees saw mass programs—those that would benefit the many rather than the few—as most important. And in setting priorities of people to be served they gave highest place to children. Women and working adults were also singled out as groups requiring special consideration.

All three conferences faced the need for priority setting for social programs in countries low in resources and trained personnel. The nature and extent of these they saw as emanating from each country's own economic and cultural situation—what the people wanted, what the country could afford, and what the policymakers were willing to provide. They saw that the less the country was developed and the greater its needs the stronger hand the government would have to play, but they never disregarded the importance of voluntary effort both in pioneering in new directions and in picking up the threads of compassionate services left dangling by an economically oriented government program. Where a true partnership exists between government and voluntary effort, an increase in State participation in social programs is usually accompanied by an increase in voluntary efforts, it was pointed out.

An important corollary to the undisputed agreement that children come first in the world's social priorities was the unanimous recognition at the study conference on child welfare that every child needs a family of its own. For while a large proportion of the delegates to this conference came from countries where large custodial institutions are filled to the brim, the group's first recommendation was that every effort be made to keep children in their own homes. This was followed by complementary recommendations to return institutionalized children, insofar as possible, to their own or foster families, and to use foster-family care, rather than institutions, for homeless infants and young children. These were the ultimate goals, but the conferees, facing present-day realities, heavily underscored the need for educating institutional child-care workers in the basic needs of children and in changing community attitudes in regard to the importance of other people's children.

While there was general agreement about the need for governmental supervision of children's services, or supervision by an agency designated by the government, the delegates stressed the importance of a real partnership between governmental and voluntary efforts and international assistance programs in meeting children's needs.

Leadership and Training

The conferences were unanimous in placing leadership responsibilities in the formulation of social policies on social workers. These were defined, however, not as the exclusive prerogative of social workers nor indeed of the combined disciplines which serve the needs of people. Rather the social worker's leadership role was described as working with others to seek out and nourish indigenous leadership wherever it may exist in a community, whether among recognized political leaders or among those individuals whose potential for influence in the local or national community is broad.

The discussions centered on the most effective way to open the shutter of the mind of potential community leaders so that they can help communities see their own needs and work toward common goals.

The qualities to look for in potential leaders were identified in the social-work conference's commission on leadership for social policy, as: commitment to serve; a sense of priority; the ability to learn from others; the ability to awaken others to acceptance of personal responsibility. This commission recommended that more be done through family, school, church, and youth organizations to train young people for community leadership. Social workers and community leaders, it pointed out, have a responsibility to see that policymakers have information on social needs and practical solutions.

The subject of professional training was, of course, of overriding concern to the delegates of the congress on social-work education. Encouraging reports of new schools of social work in Asia—25 as compared to 5 in 1950—indicated a growing, if uneven, interest in the Asian countries in providing trained practitioners and leaders for their social programs.

This interest in filling the world's vast need for trained workers permeated all the conferences. One suggestion was to spread experience by having highly skilled social workers teach others to conduct workshops and other training devices for large groups of workers in training. Another question, not really resolved, was what obligation schools of social work have to help train village-level workers who come from many and varied backgrounds. The conviction was expressed that schools of social work have a unified body of transferable knowledge, but that this must be translated with deep appreciation of the culture in which it is to be applied.

The difficulty in countries of vast illiteracy of finding persons with enough basic education to take a training course was recognized as a formidable hurdle. In their reports to the social-work conference country after country named provisions for general education—teachers, buildings, and equipment—as their country's primary social need.

New Techniques

All the conferences designated the incredibly awesome task of breaking through the widespread ignorance which exists in populations lacking in education as a prerequisite to the success of almost any social program. They saw that corporate illiteracy can defeat technical-aid programs and that unless attitudinal changes can be achieved in many areas superstition will stand in the way of economic and social progress. Such changes, it was pointed out, rarely come about without the personal touch of demonstration, as in community-development and technical-assistance programs.

The social workers saw their major role in such efforts as making their attitudes, knowledge, and skills available to all persons engaged in such programs. This might be accomplished, according to the social-work conference's commission on community development, by including community-development content, field work, and research in social-work schools to the end of training a new kind of multipurpose worker.

The development of new techniques was also suggested for meeting some of the disrupting forces of family life by bringing some of the advantages of cities to rural communities and some of the charm of rural life to the cities.

Thus these conferences all revealed that social workers the world over are today reaching out for new ideas and methods for bringing their knowledge, skills, and points of view to bear upon the vast problems of human misery—and are even daring to take a look at prevention. In calling for planned social programs to increase the resources for meeting social needs in the have-not countries, Dr. Myrdal saw the very vastness of these problems as an opportunity for social inventiveness. Said he: "The vicious circle where *poverty is its own cause* . . . can be turned into a virtuous circle, where meeting the social needs in a rationally planned fashion is cumulatively raising levels of production." He saw it as the art of the social-work profession "to plan in a rational way for this turn of the mechanism of circular causation."

And at Home

For everyone attending these conferences, the 20th-century goals will have different meanings in national application. I came away from these meetings with questions we all need to examine in the United States:

In our country, what does it mean that we believe human beings should be freed from all unnecessary limitations, to develop their greatest potentials? What actions does this belief demand throughout the vast sweep of our country from all devoted to health and welfare service? What can a well-developed country afford in the way of social program?

Are we keeping pace with the needs of the most vulnerable segments of our rapidly expanding population? What sense of purpose are we providing our own youth comparable to the pioneer spirit that can motivate young people in developing countries?

Can we social workers find ways of making our experience a more integral part of the country's whole social process, participating in molding the changes that are affecting our communities, our family life, our children? How can we revitalize our determination to raise the national standards of thought and action in order to build to the greatest potential the natural assets our country has in its children and youth? What measures can we take to create a better understanding of human needs here at home in order to clear away our own pockets of social handicap, so that this country can further demonstrate that human welfare is indeed a practical objective?

Some impressions oj . . .

SOCIAL WELFARE IN ASIA

MILDRED ARNOLD

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HOW CAN ANYONE sort out from a myriad of impressions a few that will truly reflect a tour of seven Asian countries, including attendance at the Ninth International Conference of Social Work and at study groups in each country? How can anyone, in a few succinct paragraphs, give any clear picture of the stirrings, the strivings, and the struggles going on in these countries? Everywhere were new social-welfare programs—both government and voluntary—almost all of them hampered by an insufficiency of funds and of trained personnel.

First and foremost, I was impressed with the sense of urgency on the part of many people in most of these countries—the belief that independence and the new social-welfare programs must bring quick results in improved conditions for people; that the mass of the people must experience the results of independence more intimately and must see them reflected in higher standards of living more quickly. The people in these developing countries had high hopes for social change with the coming of independence but these hopes have not yet been realized to any great extent. Results are not coming fast enough. Sickness, hunger, and homelessness are still very much in evidence. The new programs must chalk up sound accomplishments soon or reactions against the governments may set in.

Unfortunately independence does not always bring about a higher standard of living immediately, and the vast numbers of people who live in small villages in these countries have experienced little real change in their daily lives. In many countries to counteract this disappointment, village development programs are being stepped up considerably.

I had not fully realized how ancient many of the civilizations in these countries were—countries whose cities and villages often go back 2,000 years before those in Europe. These civilizations were often cut off from the rest of the world for long periods of time. Japan, for instance, was completely isolated for 1,000 years, during which time no one was allowed to enter or to leave the country. This lasted until about 90 years ago—a fact that most of us forget when we consider modern Japan.

Isolated as they were from the world these countries developed their own peculiar customs and practices. Religion, usually a form of Buddhism, permeates every aspect of their lives, and the large family extending even to distant relatives is the core of all living. Now these people are attempting to adapt themselves to modern ways, to industrialization, and to all the many social problems growing out of the complexity of today's world. How can they retain what is good in their own culture and yet reap the rewards of the modern world?

Many people in these countries see social welfare services as a basic part of their religious beliefs and ideals. This was expressed poignantly by Dr. Thein Maung, the Deputy Prime Minister and Minister of Social Welfare in Burma. He stated that over 90 percent of the people of Burma are Buddhists. Under Buddhism, they have been taught since childhood to radiate and transmit boundless love to all beings. Held before them is the noble example of the Lord Buddha who persistently rendered social services and worked for the welfare of the world in one form of existence after another through many eons. That is the reason, the Prime Minister said, for Burma's enthusiasm for social work and social welfare. That is the reason, too, why social workers are held in high esteem in this country.

Although Burma has had its independence for only 10 years, three national organizations for social welfare have already been established. A Ministry of Social Welfare, organized in 1953, has eight divisions providing probation, rehabilitation of the handicapped, services to children and young persons, special services to girls and women, care of the aged, research and statistics, training, and rural welfare and community development. This department gives technical assistance to the townships, each of which has a social welfare officer. There is a Union Council of Social Services with a membership comprised of voluntary agencies, which in Burma provide institutional care. Burma also has a Commission for Social Planning which carries responsibility for overall planning in the social-welfare field.

A day nursery in Japan. Provision for the day care of children is becoming increasingly necessary in Japan and many other parts of the East—as well as in the West—as more and more women go to work outside their homes.

The dignity and worth of the individual is beginning to be emphasized in these Asiatic countries. This is sharp contrast to the situation just a few years ago. When I attended the International Conference of Social Work in Madras, India, in 1952 the struggle for mere existence was uppermost. Now countries seem to be looking a little more closely at the people comprising the mass of humanity in their populations and are showing concern for their individual welfare. True, this development is slow but it is coming and it is unmistakable.

In the study group on "Focal Points for Community Planning and Action" of the International Conference, of which I was a member, the basic concern of social work as being for the individual, his dignity, and his rights was brought out clearly. One of the Japanese participants said to me, "The United States has achieved so well this concern for the individual. Won't you tell us how?"

Three countries we visited are under military rule at the present time, a reflection of the unsettled political situation in many of them. But even so, in some instances, they are using this interim rule for improving conditions of the people and the country. Rangoon affords an example. Before the war this was considered one of the cleanest cities in the Orient. But the devastation of war and the flood of refugees that followed from North Burma took their toll in degrading conditions and filth. Under the leadership of the army, there is now an organized campaign whereby thousands and thousands of volunteers are engaged in "cleaning the towns and cities with sweat," as the Deputy Prime Minister said.

I was impressed with the Japanese people. They have many rare qualities—an incredible capacity for work, the loving care they give their small plots of land and their possessions, their efficiency, their love of beauty. Husband and wife labor tirelessly from early morning to evening on the 2 or 3 acres they own. The Japanese have great organizational ability and are very efficient in everything they do. They will stay endlessly with a problem until it is solved. These characteristics should have value in building up their social-welfare programs.

I must also say a word about the people in one of our own Territories, Hawaii, perhaps soon to become our 50th State. By nature, the Hawaiians are a "giving and loving" people, warm and responsive. I was told that a professor who has spent some time in Hawaii studying its native language could find no word for "hate" but found over 300 words for "love." The Hawaiian people are proud of their rich background of racial mixtures and cultures. They like to have their children introduced as "half Hawaiian and half Korean" or "half Hawaiian and half Japanese," as the case may be.

Last, I was greatly impressed with the fact that all countries in the world are dealing with the same basic problems in social welfare—poverty, poor housing, homelessness, neglect of children, lack of funds for financing programs, and the need for coordination, for getting at the facts, and for doing research. To be sure, great differences exist in the size of these problems and in their characteristics, in the emphases the different countries are giving to them, and in the stages reached toward their solution. But social welfare, I am convinced, is becoming a universal expression and a universal concept. Governments everywhere are trying to do something about the social problems of their people and are putting forth tremendous efforts in trying to meet them.

International Publications

SUMMARY OF 4-YEAR REPORTS ON HEALTH CONDITIONS IN THE AMERICAS, prepared for the XV Pan American Sanitary Conference. Pan American Sanitary Bureau, regional office of the World Health Organization, Washington, D.C. Scientific Publication No. 40, 123 pp. Single copies are available without charge from the Bureau.

This report, compiled from information supplied by the 21 American republics and the Western Hemisphere territories of European countries, is the first in its series to include a chapter on maternal and child health. The previous report showed that over 40 percent of the population in many of these areas were under 15 years of age.

Data in this section are provided on the extent and causes of infant, childhood, and maternal mortality in the various countries and territories, and on maternal and child-health activities. The statistics show wide variations—infant death rates in 1956 running higher than 100 per 1,000 live births in some areas and as low as 22 in Hawaii and the Netherland Antilles. Congenital malformations and diseases of early infancy were the leading cause of infant deaths in all except 2 of the 26 areas reporting on causes of deaths of infants in 1956.

The death rate per 1,000 population for children 1 to 4 ranged from 1 to 42 in 1955. Accidents are shown as the leading cause of death in this age group in Canada and the United States (countries with relatively low death rates), with gastritis being the leading or second cause in most other reporting areas.

All countries show lower death rates for children in the next older group, children of 5–9 years, the rates ranging from 0.3 to more than 9 per 1,000 population. Among children 5–14 accidents appear among the five leading causes of death in all countries, and as first cause in well over one-half of them.

Subjects of other chapters of the publication include general vital statistics, communicable diseases, sanitation programs, medical and health personnel, national and local health services, and hospital facilities.

DISCUSSIONS ON CHILD DEVELOPMENT: A consideration of the biological, psychological, and cultural approaches to the understanding of human development and behavior. Edited by J. M. Tanner and Bärbel Inhelder. Vol. III. The proceedings of the third meeting of the World Health Organization Study Group on the Psychobiological Development of the Child, Geneva, 1955. International Universities Press, New York. 1958. 223 pp. $5.

Discussions of four subjects are reported in these proceedings of a week-long meeting: (1) the childhood genesis of sex differences in behavior; (2) sex differences in play construction of 12-year-old children; (3) the syndrome of identity diffusion in adolescents and young adults; and (4) the psychosocial development of children.

An essay-review . . .

PARENT GROUPS IN TOTAL FAMILY THERAPY

MARION F. LANGER, Ph. D.

Executive Secretary, American Orthopsychiatric Association.

MILLIONS OF PARENTS are reached daily every month in this country with advice on child care by individual and group counselors, newspaper and magazine writers, and radio and television commentators.[1] Among the organized groups providing parent education are: Federal, State, and local governments; more than 30 major national voluntary agencies including school, church, medical, home economics, and other groups; and hundreds of local organizations.[1]

Various forms of parent education have developed under these different auspices. Different needs among parents have been recognized and effort made to adapt structure and techniques to meet them. However, a definite trend away from the didactically planned single session devoted to imparting information has become discernible. The emphasis has shifted to small discussion groups allowing parents to exchange their ideas and experiences with the help of a leader.

Originally, these discussion groups were provided for "normal" parents with "normal" children. Their major objective was to facilitate the parents' understanding of child development and of their common concerns about their children in the effort to achieve better "mental health" for children. They have been widened in their use to include expectant parents and parents of physically and of mentally handicapped children.

S. R. Slavson, in a new book, "Child-Centered Group Guidance of Parents,"[2] describes an extension of the discussion-group technique to parents of emotionally disturbed children in the clinical setting of the Jewish Board of Guardians, a voluntary children's agency in New York City.

The experiment had its beginnings in the author's work in the community with discussion groups of young parents who on their own initiative sought a group learning experience. The goal of this work was preventive—to help the parents "avoid the pitfalls in the rearing of their children." On the basis of his experience and observations with these groups the author refined methods for a program of group sessions with parents of children undergoing treatment for emotional disturbances—groups with a therapeutic rather than merely a preventive aim in regard to children.

Family Treatment

The parent discussion group is one part of the clinic's treatment program of total family therapy. The father and mother, if it is feasible, attend separate discussion groups. The child is either receiving individual therapy or activity-group therapy. In some instances, one parent may be participating in a discussion group, while the other parent may be receiving individual therapy. The goal of total family treatment is to achieve "a change in the 'family climate' as well as in the functioning of the individuals in it." Effort is directed toward "altering the relation between the parents and the children."

In this book Mr. Slavson focuses chiefly on the techniques evolved in the parent groups. He analyzes the sessions in detail, considering the content of parent-child relations, principles and practice in child-centered group guidance, the development of parental understanding of children, the reduction of family tensions, the pitfalls of the technique, the criteria for selection of parents, the dynamics of the process, the differences between group guidance and group psychotherapy, and the implications of the process for general mental health.

In defining child-centered group guidance of parents, Mr. Slavson says: "The phrase 'child-centered' distinguishes it from guidance and counseling in which the total life situation and relations of the participants are considered. In the technique with which we are dealing here, attention is focused on the child and the child alone—his nature, his fears, his needs, his strivings, his behavior and its meaning, and the most efficacious way of dealing with him and his acts in the interest of his, the family's, and the community's mental health."

The groups consist of 8 parents each, meeting on alternate weeks for 90 minutes to 2 hours. Parents are grouped so that their children are of nearly the same age and of the same sex. The discussions are at all times centered on "actual" situations as they occur in the lives of the parents and "only those that relate to their children." The ultimate aim is defined as "a change in the parents' behavior toward their children, stemming from deliberative, controlled, and understanding reactions and reflections instead of impulsivity and the irrational emotionalism of the past."

The Goals

A number of aims of this process are delineated; some major, others subgoals of the major objectives. One major goal, the author says, is: "to demonstrate that even parents who have already made serious mistakes with their children can, through their own effort, find ways of correcting past errors, eliminate tensions, reduce antagonisms and hostilities, establish favorable relations with their children and mates, and create a relaxed atmosphere in the home."

Subsidiary aims are part of the dynamic process and include:

"The participants buttress each other's positive trends and constructive elements in their lives. . . . the group members with the aid of the leader guide one another toward discovering effective ways of dealing with hitherto frustrating situations, thereby eliminating or reducing their sense of failure. . . ."

Parents achieve "self-acceptance."

"Awareness is accelerated and enhanced through seeing one's self mirrored in the acts of others."

As "discovery that one is not alone occurs," a universalization of experience as a parent is achieved.

"Identification with a wholesome parent figure"—through the leader's acceptance of members of the group.

"Acquisition of knowledge."

"Reduction of ego load."

"Reduction of guilt."

"Buttressing of parental instincts and ideals."

"Support of cultural values."

"Widening fields of operation."

"Supervised practice in parenthood."

Essential ingredients for the achievement of the major goals of the group, according to the author, are the skill of the group leader and the proper choice of members of the group.

These are the same goals accepted by everyone working in the field of mental health as of vital importance for family living.

Of Mental Health

We would all agree, I believe, with Mr. Slavson's repeated emphasis on the importance of parent learning. There is general recognition of the fact that the physical achievement of parenthood is not synonymous with the ability to rear children in a rapidly changing culture. With the increasing evidence of emotional disturbance among children, in the adult population, and in family groups, concern continues to mount as to how to provide for more adequate family living.

Four significant trends today appear to have their origins in this concern:

1. The most prevalent trend is the development of the wide variety of programs to help parents learn to function in ways that will encourage healthier emotional development of their children or, as frequently expressed, prevent emotional disturbance. The goal is generally change in parental attitudes to children and, as a consequence, change in parent-child interactions, with a further consequence of better mental health of the child.

Mr. Slavson illustrates this when he says: "When parents can accept without fear and guilt their unconscious trends, rather than overidealize themselves, they will be able to function more constructively and lay a sounder foundation for the mental health of their children." He also says: "Were child-centered guidance groups for parents to become an integral part of young and older women's and men's clubs and organizations and used extensively in high schools, young adult groups, college classes, neighborhood and church groups, the level of mental health in the community would in time rise immeasurably."

Part of this trend, as demonstrated by Mr. Slavson's statement, has been to assume a causal relation between parent education—the presentation to groups or the use by groups of human development materials—and the improvement in the mental health of children.

2. A steadily growing trend is the recognition of need for more knowledge as to the connections between parent education, change in parental attitudes, and improved mental health for children. More and more the question is being asked: What is the evidence that a demonstrated change in parental attitudes as a result of an educational program is related to a subsequent change in the mental health of the child?

Recognition of the need for research to evaluate programs for parent education is one part of this trend. Another part is the initiation of such research. Orville Brim, Jr., of the Russell Sage Foundation has reported that there are now about 20 evaluative research studies of programs of parent education.[1] After analysis of the results of these to date, he has concluded that they do "not show us to be in a strong position in respect to the scientific bases of our educational efforts" and that we need "more knowledge about the effects of what we are doing than we have at the present time."

3. A third trend carries a step further the question of evaluating the effectiveness of parent education in achieving better mental health for children by looking into the meaning of mental health and asking what are its components. Marie Jahoda, in her recent book, "Current Concepts of Positive Mental Health,"[3] says: "There is hardly a term in current psychological thought as vague, elusive, and ambiguous as the term 'mental health'."

Dr. Brim, in his reviews of the evaluative studies of parent-education programs, points to what he considers a crucial problem in such studies—"the conceptualization that deals with the characteristics of the child which pertain to his mental health."[1] This conceptualization might be a view of mental health as composed of a variety of measurable skills. In other words, if we develop a program with the goal of improving mental health through bringing about change in individuals, can we define the qualities in which we anticipate change and determine whether our objective is attainable by the processes utilized? While these are not simple problems, easily solved in work with individuals in their interactions with each other and society, they obviously require our concentrated attention.

4. The fourth trend, an increasing move toward family-oriented efforts, is well demonstrated by the three-pronged program described by Mr. Slavson. In this program re-education or child-centered group parent guidance involves all members of the family. While the focus in each part of the program is the child, a basic consideration in the process is the interaction of parents and child. As Mr. Slavson points out, "total family therapy is becoming increasingly accepted in mental-hygiene practices."

One wishes a method of evaluating change in the member of the group and the effects of these changes on the child as well as on the family equilibrium had been built into the process of the program Mr. Slavson describes. Case illustrations report changes of attitudes to children and improvement in the family climate of the individuals concerned. We need to know more about the degree of these changes, and of their meaning for the children and for the family structure.

Mr. Slavson's material stimulates interest in the interaction among the members of a family and in the family's interaction with the culture in which it lives. His focus on methods by means of which individual family members can learn to make their adaptations to each other and to their social world is well defined. It leaves open, however, some questions that are implicit in any public mental-health approach. Is the human being's function only to make adaptations? Are there no difficulties in individual interaction with society that do not stem directly from the parent-child relationship? Do we consider as fixed and unchanging the function of the behavioral and social scientist to look at the culture without recognizing whether it is in a state of change or in need of change?

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[1] Brim, Orville G., Jr.: Recent research on effects of education in human development. *In* Four basic aspects of preventive psychiatry; a report of the First Institute on Preventive Psychiatry, State University of Iowa, 1957. Ralph J. Ojemann (editor). State University of Iowa, 1957.

[2] Slavson, S. R.: Child-centered group guidance of parents. International Universities Press, New York, 1958.

[3] Jahoda, Marie: Current concepts of positive mental health. Basic Books, New York, 1958.

BOOK NOTES

METHODS FOR RESEARCH IN HUMAN GROWTH. Stanley M. Garn and Zvi Shamir. Foreword by A. Ashley Weech. Charles C Thomas, Springfield, Ill. 1958. 121 pp. $4.75.

Written to guide investigators, especially those working as part of a team, in planning and executing research in growth, this book stresses practical methods rather than findings. It also offers suggestions concerning areas in which the authors believe research would be most productive or nonproductive at this time.

Among the subjects discussed are longitudinal *vs.* cross-sectional research, pediatric examinations and health records, physiological and biochemical tests, anthropometric measurements, rating sexual maturation, minimizing X-ray exposure, and graphic representation of growth data.

The authors urge research workers to pay attention to the human factor in investigation—the feelings of parents and children and of such assistants as nurses, photographers, and X-ray technicians.

Dr. Garn is chairman of the physical growth department, Fels Research Institute. Dr. Shamir is chief physician, department of pediatrics, Hadassah-Hebrew University Hospital and Medical School, Jerusalem, Israel.

THE GANG; a study in adolescent behavior. Herbert A. Bloch and Arthur Niederhoffer. Philosophical Library, New York. 1958. 231 pp. $6.

Gangs are an outgrowth of conflict between adolescent boys and adult society rather than a phenomenon of low socio-economic status, say the authors of this book, a professor of sociology and a police lieutenant, drawing on their own observations in work with groups as well as on the sociological and psychological literature in presenting their theory. The conflict between youth and adults arises, they maintain, in reaction to the prevailing culture's lack of the capacity or willingness to let the growing youth play an adult part in regard to family life, gainful employment, and sexual behavior.

Since our society does not make adequate preparation for inducting its boys into adult status, adolescents spontaneously develop some such induction, reinforcing it with a group structure, which in some circumstances becomes a delinquent gang, the authors explain. They add that membership in such a group appears to satisfy deep-seated needs experienced by adolescents in all societies, including our own.

The authors describe various puberty ceremonies carried on by a number of primitive societies and point out similar practices in gangs and student groups, noting that such practices relate to social rather than biological puberty, and that the "social-puberty" period lasts longer in our society than in some others.

A yearning for power and a need to prove their masculinity to the world and to one another are regarded by the authors as the background for activities that seem senseless, such as vandalism. Gang actions by middle-class adolescents, they say, result from anxiety, dependence on other gang members, and conformity, which lead these boys to satisfy compulsive personality needs in the "electric tension of the gang situation."

The book includes a detailed factual account of the actions of several interrelated predatory gangs in their struggles with the police.

THE PSYCHODYNAMICS OF FAMILY LIFE; diagnosis and treatment of family relationships. Nathan W. Ackerman. Basic Books, New York. 1958. 379 pp. $6.75.

Written by a psychiatrist, this book examines the problems that face psychotherapists in treating children and adults and stresses the necessity for treating both within the framework of their families. Addressed chiefly to practitioners of psychotherapy and others concerned with mental-health efforts it is, in the author's words, an attempt to "present a unitary conception of the mental-health problems of family life" by correlating "the dynamic psychological processes of individual behavior with family behavior."

In a section on the theoretical aspects of the processes of family life, the author explains Freud's views on the family and on personality; notes the social role of the individual and the need for preservation and growth of the self; and discusses family identity, stability, and breakdown.

Another section, on clinical diagnosis of family relationships, discusses various types of behavioral disturbances among parents and among children and adolescents, and psychosomatic illness in relation to family disturbance. This section includes several guides for the therapist in the form of outlines for collecting data leading to family diagnosis, for evaluating marital and parental interaction, for evaluating a child's personality, and for determining the level of a child's maturation.

Methods of treating family disturbances are discussed in the third section, which notes goals of psychotherapy and several of its techniques, especially as used with mothers and children, and gives an example of treatment of a family as a whole.

The final section includes a proposal for a method for research in the dynamics of family life.

The author is associate clinical professor of psychiatry at Columbia University.

THE HIGHFIELDS STORY; an experimental treatment project for youthful offenders. Lloyd W. McCorkle, Albert Elias, and F. Lovell Bixby. Henry Holt & Co., New York. 182 pp. $3.50.

The first 5 years of operating the program at Highfields, a small residential center for rehabilitating delinquent boys on probation, are reported on in this book by three authors—the present head of the center and two other staff members of the New Jersey State Department of Institutions and Agencies. The boys, 16 years old and younger, are sent by juvenile-court judges to Highfields, but are not committed to it; they are allowed by the judge to be treated there as a condition of their probation.

As described, Highfields does without custodial staff and bolts and bars and has few formal rules. Usually fewer than 20 boys live at Highfields at one time, and their usual stay is about 4 months.

At the core of the treatment described is a form of group therapy called guided group interaction, which is planned, the authors say, to help the boys gain insight into their behavior, to accept responsibility for it, and to change their attitudes and conduct from delinquent to normal.

The book reports a study of the effects on young offenders of the Highfields program compared with that of a conventional reformatory. In what the authors call a somewhat oversimplified statement, they note that the Highfields "graduates" seemed to have gained self-respect; the other boys seemed to have lost some of theirs. The report showed much less recidivism among the Highfields boys than among the other boys.

A comment on the success of the experimental program for juvenile delinquents described in this book is provided in an appendix, which gives the text of legislation signed by the Governor of New Jersey in June 1957, authorizing establishment of additional similar facilities in the State.

IN THE JOURNALS

Advances in Child Health

Advances made during the past decade in safeguarding the lives of mothers and children and improving their mental and physical health are reported by Hilla Sheriff, M.D., in the December 1958 issue of the *Journal of the American Dietetic Association.* The author is director of the maternal and child health division of the South Carolina State Board of Health.

One of the advances she notes is the broadening of the concept of maternal care, which now takes account of the nutrition and health status of the potential mother during her entire life span. Another advance achieved, through public-health techniques, is the saving of the lives of many infants. However, the author notes that little reduction has occurred in the death rate of infants under a week old and of early fetal losses.

Progress made during the decade in preventing or treating a number of diseases, including rheumatic fever, poliomyelitis, and congenital heart conditions, is noted by the author. Other advances in child health she attributes to: acceptance by State crippled children's programs of increasing numbers of children with handicaps other than the orthopedic; development of State programs for the mentally retarded, including efforts to find the causes of retardation; establishment of a network of poison-control centers that have been set up throughout the country; recognition of the association of overadministration of oxygen with retrolentral fibroplasia; and a "long overdue impetus to the development of healthy personalities in children" given by the Midcentury White House Conference on Children and Youth.

Among new problems that arose during the decade, the author especially notes the hazards of radiation.

Interrupted Education

In *School Life* for December 1958 the Secretary of Health, Education, and Welfare points out what loss of regular schooling may do to young people in Little Rock, Ark., and Norfolk, Charlottesville, and Warren County, Va., where 13 public schools failed to open last September. ("Effects of Closed Schools," by Arthur S. Flemming.) Of the 16,400 boys and girls shut out of their regular schools, the Secretary notes that while about 3,000 are traveling to public schools in other communities, and a few hundred are in private schools, the large majority are receiving only emergency schooling and about 3,400 are receiving no schooling at all.

Some of the young people now out of school, the Secretary points out, lose their motivation or desire to return to school or to go on to college; many will find it hard to find their place in the normal sequence of the school program. Those who had planned to go to college next year will find serious obstacles in their way; some may have difficulty meeting college-entrance requirements.

Among possible long-run effects of sporadic or insufficient schooling on the boys and girls affected, the Secretary foresees: the lessening of future earning power and productivity; reduction of their sense of purpose, possibly leading to delinquency; and interference with their development into an educated and informed citizenry.

The Secretary concludes by affirming his confidence that as such losses become more evident the schools will be opened under policies that will be in harmony with decisions of the courts.

Children Elsewhere

The winter issue of *Child Study,* planned to spread information on child-rearing practices in other countries as a small part in reducing international tensions, begins with a discussion of the importance of an integrated value system by anthropologist William Madsen and goes on to provide glimpses of child life in various cultures. For example, Milton J. E. Senn, M.D., reports that little children are treated tenderly in Russia, but that pressures on Russian children to achieve success are extreme, and he asks, "Are Russians too hard on their youths? Are we Americans too easy on ours?"

Two authors emphasize the strength of tradition in French family practices, but both note that the French are slowly accepting new ideas in child rearing. Day-care centers for Jewish children in Morocco, Tunisia, and Iran are the subject of an article, and a historical sketch of the development of modern child-care customs in Finland is also presented.

A Hawaiian writer of Japanese descent notes changes that have taken place with time in children's upbringing in her ethnological group. Finally, the wife of an Indian member of the United Nations Secretariat anticipates the problems her thoroughly Americanized children will face when they return to the culture of their own country.

HERE AND THERE

Perinatal Casualties

Approximately 100 professional people concerned with the administration of maternal and child health and crippled children's services, from 12 Midwestern States included in two regions of the Department of Health, Education, and Welfare, met in Minneapolis for 5 days in December in an institute on perinatal casualties. This was the first joint institute arranged by the departments of maternal and child health of the Schools of Public Health of the Universities of Minnesota and Michigan in cooperation with the State maternal and child health and crippled children's agencies of Minnesota and Michigan. Participants in the institute included physicians, social workers, nurses, nutritionists, and physical therapists.

The fact that patients with problems of fertility show a close relationship to those with gynecological problems led to a discussion of ways of providing preconceptional care. Emphasis was put on the importance of recognizing conditions that may lead to reproductive complications before pregnancy occurs. Studies were described which showed that two-thirds of the incidence of perinatal casualties occurs among approximately one-fourth of the maternity patients. Emphasis was placed on the need for better and more complete pathological services in determining actual causes of infant deaths. The need for perinatal pathologists to communicate with clinicians and paramedical personnel in collecting all facts in a case was considered by several conference speakers to be most important in determining the causes of death.

Alteration of the physical and social environment in the reduction of perinatal wastage was recognized as an important factor. The function of a medical teaching center in encouraging regional hospital conferences and in providing consultative and educational services was emphasized.

More adequate programs of care for mothers and infants in the low-economic groups with provisions for payment for medical and hospital services were pointed out as essential, as well as specialist services for women with repeated reproductive failure. Followup of "suspect" infants who are born under unfavorable conditions was advised.

—*Ruth G Taylor*

The Mentally Retarded

As a step toward arriving at a philosophy concerning a fair division between parents and the State of financial responsibility for the care and training of mentally retarded children in State institutions, the National Association for Retarded Children recently collected information from States on institutional practices regarding service charges.

The results show that institutional care, including training, of the blind, the deaf, and other handicapped children is usually provided at the expense of the State, regardless of their parents' ability to pay, but that nearly all the States require payment for the care and training of the mentally retarded. The fees are usually set according to a sliding scale, ranging up to a set maximum. In some States the maximum is set by law; in others it is based on per capita costs of care, which in most States includes the cost of education, training, and rehabilitation, and in some, also research and public-relations expenses. In many States the difference between an "adjusted charge" and a "maximum charge" accumulates as a debt against the liable persons—parents, self, children, guardian, and, in some States, even grandparents and siblings. Only five States do not require payments of parents. In only two States does the required charge stop when the patient reaches the age of 21.

Observing that as a rule the parents of an institutionalized mentally retarded child wish to continue their financial responsibility for his maintenance, the association suggests that, while they should be encouraged to do this, society should help to bear the expenses incurred as the result of the child's handicap, and that the cost of his training should be paid for by the community, as is the cost of public-school education.

In an effort to specify some basic principles on which an equitable plan for determining and collecting fees can be established, the association offers a number of recommendations.

Among these are: that each State resolve the question of charges according to its individual circumstances and in "consistent relation" to its methods of financing other social and educational services; that charges to a family be determined in the light of the family's needs as a whole, allowing leeway for the future educational needs of other children in the family and provision for old age; that no charge be made after the child reaches the age of 21; that the persons financially responsible under the law for the child's care should include only the parent or the child himself; that a clearly defined policy be developed through which the person liable for payment may ask for reconsideration of the decision.

The report of the study is obtainable from the Association, 99 University Place, New York 3, N.Y. ("Responsibility for Costs of Maintenance and Training in Public Institutions for the Mentally Retarded." Price $1.)

Juvenile Delinquency

Two universities at opposite ends of the country, the University of Southern California, in Los Angeles, and Syracuse University, in Syracuse, N.Y., are in the early stages of interdisciplinary planning for combination research, demonstration, and staff-training projects to test the soundness of theories for the prevention of juvenile delinquency and to train persons who work with delinquents or potential delinquents. Each recently received a grant from the Ford Foundation of some $700,000 to be expended over a 5-year period.

In Los Angeles the project, known as the Youth Studies Center, operates with guidance from two groups, a university committee and an advisory council. The center has three divisions—research, community demonstration, and education and training—each with an advisory committee from the center's advisory council, which is composed of community leaders and professional persons concerned with the welfare of youth. The 11 cooperating divisions of the university include the college of letters, arts, and sciences; the schools of education, social work, public administration, law, medicine, and architecture; the departments of sociology, psychology, and religion; and the office of the dean of students.

At Syracuse the Youth Development Center, with similar operating divisions and community-university advisory committees, is under the direction of the university's vice-chancellor, with a professor from the school of social work serving as executive officer and coordinator. Part of its activities will be to set up demonstration research projects in high-delinquency areas—under consideration is one to be located in a school and another in a public housing development.

The staffs of the two centers plan to come together regularly to exchange ideas and experiences.

Camping

The camping service of the Community Council of Greater New York is developing a set of guiding principles for fee charging in summer resident camps run by social agencies. The project, being carried out by a number of special committees, was undertaken following the completion of a study of current fee-charging policies and practices made last summer to provide a basis for community-wide reconsideration of this aspect of agency policy.

The survey, which covered 108 camps operated by 73 social agencies, found a wide variety of practices ranging from no fee at all for any camper to flat fees charged regardless of income. A total of 53 agencies charged fees of some kind, 30 of them on a graduated scale related to ability to pay.

Detailed results of the study are available in a mimeographed report from the Council, 345 East 45th Street, New York 17, N.Y. Price $1.25.

Against Polio

Thirty officials representing national medical groups, voluntary health organizations, and State and local health departments met in Washington at the call of the Surgeon General of the Public Health Service in a day-long conference early last December to review the past year's polio experience and to map out ways of promoting further vaccination before the summer of 1959.

Primary conclusion of the conference was that intensive campaigns by local communities will be necessary throughout the coming months if millions of unvaccinated people under 40 in this country are to be protected before next summer. The conferees suggested that such campaigns may need to be organized on a block-by-block, home-by-home basis.

A special effort is needed, the conferees agreed, to promote vaccination of children under 5 years of age, among whom more than half the cases of paralytic polio occurred in 1958, especially in the lowest socioeconomic groups, where vaccination is rarest.

. . .

Paralytic polio cases occurring during 1958 exceeded the number that occurred in the same period of 1957 by 925, according to the Public Health Service. In the six States most seriously affected the majority of persons who had contracted the disease by mid-October—416 out of 781—were children under 5. Of these 416 children four out of five had received no vaccine.

Health Studies

The Community Research Associates has recently reported on the results of a 3-year project in Washington County, Md., designed to intensify the community's efforts to "rehabilitate" families with a disabled member, who are unable to pay for medical care. The project, staffed by an interdisciplinary team, directed by a public-health physician, and including consultants in social casework, public-health nursing, and vocational rehabilitation, and a research analyst, sought to integrate the services of community agencies already helping the families so as to take into account the interrelation of family medical and social problems. The goal was to reduce the disability and the family's dependency.

For each of about 400 families the project staff, with the help of the agencies, made a medical and a psychosocial study and an overall diagnosis. The staff also developed treatment plans for about two-thirds of those families and transmitted the plan to the agency primarily responsible for helping the family. That agency worked to carry out the plan insofar as possible with the resources available; the project staff took no part in the treatment. The one-third for whom no treatment plans were made continued to receive the agencies' services as before.

Although much of the recommended treatment could not be completed within the time limits of the project, the staff reported that "improvement in indigency status and achievement of reasonable rehabilitation goals" were noted in one-sixth or more of the families. Measurable decrease in disability resulting from chronic conditions was rarely achieved, but "considerable improvement in medical treatment and in use of medical services" was noted. The only new service provided for the community in connection with the project was a medical diagnostic clinic developed by the project staff in cooperation with the county health department. The clinic continued in operation after the project ended.

The report of the project, "Health and Welfare Issues in Community Planning for the Problem of Indigent Disability," has been published as a supplement to the November 1958 issue of the *American Journal of Public Health.*

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A three-part study of the effects of oral and facial deformity on children's personalities is being undertaken by the Cleft Palate and Dentofacial Institute of Tufts University. The study is being carried out as part of the Institute's diagnostic and treatment functions by its psychiatric treatment service.

One part includes periodic observations of children with such deformities at a developmental clinic established especially for the purpose. Babies with oral-facial deformities are being enrolled at the clinic as soon after birth as possible. They are then brought for intensive observation every 6 weeks. The observation session, which lasts about 2½ hours, includes a physical examination, developmental tests, an interview with the child's mother, and detailed observation of the baby's behavior, especially of his feeding behavior. Occasionally the child is observed in his own home. If the family has no private physician, the developmental clinic serves as a well-baby clinic.

Another part consists of a yearly

psychiatric followup of a group of 12 children who were first diagnosed at the Institute when they were of preschool or early school age. A third part consists of child-guidance treatment of some of the children who have neurotic difficulties.

The study, which is part of a larger study of oral-facial deformity, supported by Children's Bureau funds available through the Massachusetts Department of Public Health, is expected to help the investigators learn more about how best to feed children with cleft palate and similar deformities, and about the least injurious ways of dealing with them.

. . .

A study of the emotional reaction of children to dental procedures involving the use of local anesthetics, being supported by the National Institute of Dental Research, National Institutes of Health, is near completion at the University of Washington School of Dentistry, where data gathered on 64 children are now being analyzed.

The children were half of school age and half of preschool age, each group being equally divided between the sexes. Each child was given a routine dental appointment during which a local anesthetic was administered, and a continuous record made of his face temperature, hand temperature, galvanic skin response, and heart rate, as well as of the conversation between the child and the dentist. Information was also gathered, through a social worker's interview with the child's mother, on the child's developmental history, his previous experience with dentistry and with medical service, his adjustment at home and at school, and his parents' attitudes toward their own dental experiences as well as toward the child's.

The study is a part of a wider program to identify methods for improving the rapport of children and dentist during treatment. Preliminary investigation of the data, the director reports, indicates that emotional tensions are as great just prior to stressful situations as they are during treatment.

Professional Education

A consultant group on medical education, recently appointed by the Surgeon General of the Public Health Service to seek answers to the question of how the supply of well-qualified physicians can be increased to adequate proportions over the next 10 years, held its first two meetings in December and February. At the Surgeon General's suggestion the group considered the possibilities of a number of tasks, including: appraising existing data, plans, and proposals related to medical schools and the Nation's needs for physicians; identifying areas of agreement and problems requiring further study; recommending (1) general actions that might be taken to achieve reasonable goals in medical manpower over the next 10 to 20 years, (2) specific actions that educational institutions, foundations, industry, and Federal and State governments might take in reaching the goals recommended, and (3) the proper role, if any, of the Public Health Service in these actions.

The Handicapped

Two diagnostic and evaluation centers for children with multiple handicaps are operating in Baltimore under contract with the Maryland State Department of Health, as a result of a recommendation of the Maryland State Planning Commission. Established during the past year by the pediatric departments of two teaching hospitals, Johns Hopkins and the University of Maryland, the centers provided the children with diagnosis, evaluation, initial treatment, and rehabilitation planning. About 600 children with combinations of such conditions as cerebral palsy, epilepsy, defects of vision or of speech and hearing, emotional disturbances, cariac anomalies, and mental retardation, are expected to receive services at the centers during the year ending June 30, 1959.

The commission recommended the establishment of such centers after a subcommittee, charged with surveying the facilities and services for handicapped children in the State, found that for many such children who had to be taken to a series of clinics a complete examination took over a year, and sometimes a child became "lost in a maze of clinics" for lack of a single responsible person to take charge of his case.

In the new centers one person takes responsibility for assembling information on each child's needs—physical, emotional, and mental—weighs the findings, explains them to parents, and decides, on the basis of discussion with appropriate professional personnel and with the parents, on a plan of treatment. The centers find that parents' time and money are saved, for as a rule even the most complex problems presented by a child's condition do not require more than 3 full days' attendance at the center.

In a team approach to fulfilling each child's needs, the centers' staffs integrate their services with those of consultants in such specialties as neurology, orthopedics, ophthalmology, and psychiatry. Their interdisciplinary staffs include pediatricians and other medical personnel, psychologists, social workers, and speech and hearing specialists.

Each center works in close cooperation with one of the two crippled children's hospitals in the city, both of which provide facilities for surgery and for long-term treatment and rehabilitation.

In addition to services for the children and help to their parents in learning how to care for them, the centers provide programs of professional education in methods of caring for handicapped children for physicians and medical students, nurses, social workers, therapists, and educators. They also carry on research in the causes and treatment of crippling conditions, and in methods of testing mental and physical potential in the child with multiple handicaps.

. . .

Near the end of a 7-year project to help adolescents who have "handicapped hearts" improve their employment qualifications—physical, social, academic, and vocational—and to help them find suitable jobs, the Vocational Advisory Service, a voluntary organization in New York City, reports these achievements: (1) establishment of a priority for heart patients at certain "key" employment agencies; (2) clarification of some rules for eligibility for military service; (3) acceptance of mild heart cases by the vocational-rehabilitation division of the State department of education. The project is financed by the New York Heart Association and the American Heart Association.

The project is giving vocational guidance and, when necessary, instruction in remedial reading, to more than 200 boys and girls with heart damage or a history of rheumatic fever, some of whom were in the eighth or ninth grade when they enrolled and some of whom had already dropped out of school. Many have gone on to finish high school, some have been placed in post-high-school vocational-training courses, and a few have entered college.

The project is also working toward such benefits as: (1) more adolescent heart clinics, with schedules that do not conflict with daytime jobs or training courses; (2) higher standards of teaching at convalescent homes; (3) community recreational facilities for heart patients.

New York City's health and educational authorities and the State vocational-rehabilitation agency are cooperating in the project.

. . .

After-school recreation programs for children with hearing defects, with a few children with normal hearing joining them, are now carried on by several Chicago community agencies as the result of a 3-year demonstration project recently completed by the Chicago Hearing Society.

Several years ago the society, which for more than 30 years had been directly helping deaf and hard-of-hearing children and adults to improve their social adjustment through recreation programs, worked out a plan with some groupwork and recreation agencies to demonstrate similar work with more children. With foundation funds, the society enabled nine agencies to establish programs for children with defective hearing, drawn from the enrollments in "deaf-oral" classes in schools; held three workshops to orient agency groupworkers to the needs of such children; and assigned a groupworker to lead programs.

Participants at the workshops agreed that many adaptations of generic groupwork methods are needed to fulfill the needs of deaf and hard-of-hearing children. Among the examples cited were: greater aggressiveness in program planning than with normally hearing children; more use of gestures and notewriting, as well as physical contact, to supplement other methods of communication; more improvisation of directions to the children; greater care in preparing the children for changes; more individual help in establishing behavior limits; more physical help, such as taking the children from their school to the agency center.

A report on the project, "Group Work with Hearing Impaired Children," is available without charge from the Society, 30 West Washington Street, Chicago 2, Ill.

Day Care

Nearly 400,000 of the 5,073,000 children in this country under 12 years of age whose mothers were working full-time were caring for themselves while their mothers were away from the home, according to preliminary estimates from a sample survey made last June for the Children's Bureau by the Bureau of the Census as part of its monthly Current Population Survey. Among these children about 138,000 were less than 10 years old. The study sample included 35,000 households, located in all the States of the Union.

The study shows that the children under 12 taking care of themselves represented about 7 percent of all the children of that age group whose mothers were employed full time. Of the other children under 12 of employed mothers, 56 percent were cared for by their fathers or other relatives; 20 percent by nonrelatives; 2 percent were in group care; and 13 percent had other provisions made for their care. One-fourth of those in group care were under 3 years of age.

Among the children between 6 and 12 the vast majority received some supervision from adults or older children, but 20 percent of those between 10 and 11 took care of themselves.

Of those under 6 years, 42 percent were taken care of by relatives other than parents. Fifteen percent were looked after by their own fathers or mothers, about 27 percent were cared for by nonrelatives, and 4 percent were in group care.

White House Conference

In mid-February the Chief of the Children's Bureau appointed Ephraim R. Gomberg, a lawyer with wide experience in social-welfare activities and planning as director of the 1960 White House Conference on Children and Youth. In recent months Dr. Gomberg has been directing the efforts of the Pennsylvania Citizens Association to modernize Pennsylvania's laws relating to juvenile delinquency and corrections. For 10 years he headed Philadelphia's Allied Jewish Appeal and for several years directed the community organization and campaign planning of the National Refugee Service. He has also worked on various types of social-welfare legislation in Michigan where he was at one time a member of the board of the State Conference on Social Work and of the State Mental Health Association. While in Michigan he taught legal aspects of social work at the Wayne University School of Social Work.

. . .

Since its first meeting last December each of the 92 members of the President's National Committee for the White House Conference has been appointed to one of five major committees: Studies; interpretation; organization and arrangement; followup; finance.

. . .

A number of recommendations for facilitating State planning for the 1960 White House Conference on Children and Youth emerged from a workshop held in Washington in mid-January under the sponsorship of the National Council of State Committees for Children and Youth and attended by representatives from 41 States. The recommendations were directed to the President's Committee for the White House Conference, the National Council of State Committees, and the Conference staff and had in large part to do with getting information to the States in regard to decisions affecting State plans; guidance in factfinding, interpretation, and committee structure; orientation of delegates to the conference. One, however, directed to the President's committee, asked that means be sought for securing Federal financial aid for the States for Conference participation in accordance with the precedents of the White House Conference on Education and the White House Conference on the Aging.

The other recommendations to the President's committee urged quick decision on State quotas for invitations to the Conference; and periodic interpretation to the Congress and to State governors of the purpose, theme, and status of the White House Conference plans.

Among the recommendations to the National Council was one asking that the council's youth members be given responsibility for orienting the youth who will be attending the 1960 Conference.

READERS' EXCHANGE

WERTHEIM: *What about fathers?*

It is interesting to find some one in Australia exploring a joint-interview technique in diagnostic and therapeutic work with emotionally disturbed children. This new exploration, described by Eleanor S. Wertheim [See "A Joint-Interview Technique With Mother and Child," CHILDREN, January-February 1959], supplements experiments of John Bowlby in London and of John E. Bell in Worcester, Mass. Bell's explorations of "family group therapy," however, have been described only in an unpublished manuscript.

Although every kind of therapeutic approach is worth exploring, the wisdom of limiting the joint interviews to child and mother may be questioned. At least two studies of the child-rearing antecedents of behavior problems in children have brought out the importance of the father. One of these is under way at the psychological clinic at the University of Illinois by Leo Hellmer, Wesley Becker, Donald Peterson, and Donald Shoemaker. The other was done at the psychological clinic at Stanford University by Albert Bandura and Richard W. Walters.

Both of these studies indicate that one important antecedent of acting-out problems is a withdrawal of fathers from active participation in the emotional interaction of the family, supplying only an irritated and erratic discipline after things have got out of hand. Dr. Bell's work has shown that some fathers do change when involved in "family group therapy."

For certain situations, joint interviews with only mother and child may be indicated, but it will be difficult to discover what these situations are without first focusing on the family as a unit.

Most of Eleanor Wertheim's discussion concerned the diagnostic advantages of joint interviews. These advantages are, however, clinical impressions. She supplies no systematic comparison of measurements of relationships in mother-child pairs with and without emotional problems. When Donald Shoemaker, starting from clinical impressions of the diagnostic value of joint interviews with mother and child in a playroom, compared pairs with and without problems, the expected differences failed to appear, but it may be that the behavior categories he used encompassed the wrong aspects of the mother-child relationship. He is now engaged in a study employing ratings of factors at a higher level of abstraction.

The therapeutic value of the joint-interview technique may be greater than the diagnostic value. Perhaps diagnosis has been overstressed throughout the past half century of psychotherapeutic effort. If, as seems evident, the child learns a major share of his "personality" in his communications with his parents, siblings, and peer groups, efforts to facilitate communication within such natural groups, and especially within the whole family, may be of the utmost therapeutic importance.

Dr. Bell's 17 family cases give the impression that large degrees of change in family relationships can result from a small number of therapeutic sessions with family groups. If this impression can be substantiated, the joint-interview and family-group approaches may provide a genuine breakthrough in helping people with emotional problems.

If this proves so, the reason may not be hard to find. In individual psychotherapy any change that occurs in a client tends to lead to surprise and even to distress in the people significant for him who had "grown accustomed to his face." The unfavorable reactions to the client's change serves to squelch his tender new habit.

In the group-therapeutic approach with "natural groups," the communication which takes place in a therapeutic session belongs to all members of the group. When changes in individuals occur, they meet acceptance and approval and so are reinforced.

In the few comments she makes on the therapeutic significance of joint interviews, Eleanor Wertheim describes a similar impression of their high and sustained therapeutic value, gained from routine reviews 2 years after therapy.

Joint-interview therapy, and especially group therapy with such natural groups as the family, should be tried more widely. Systematic comparisons of results from individual and group approaches should be coming soon.

J. McV. Hunt
Professor of Psychology, University of Illinois.

BRIM: *Some suggestions*

The problems Dr. Orville Brim uncovers bear some striking resemblances to the problems in education of children and adults in general. [See "The Sources of Parent Behavior," by Orville G. Brim, Jr., CHILDREN, November–December 1958.]

Educators seek constantly to effect improvement in the behavior of the learner. That this behavior is not always that which should have been "learned," or that failure to perform reflects relatively complex causality, is quite clearly established in the research literature. We know that the values which dominate our educational programs create conflict for certain learners and are even more deeply resisted by others. Each of the sources of parent behavior which Dr. Brim suggests are equally potent factors in the educational process per se.

If parent education is compared to education generally, it may benefit from at least two parallels which emerge. The first is that today's educators pay close attention to individual differences in the learner's background and performance and attempt to adapt the teaching process accordingly. Dr. Brim's pleas for additional research in parent education might be augmented to include information about the typical performance of parents. There have been attempts to ascertain the current child-rearing practices of various parent groups, but there is still a need for improved methodology, objective instruments and techniques, and more extensive study of parent practices.

The second parallel relates to responsibility. Our schools do not assume total responsibility for the education of pupils, nor should they. Pupil behavior, like parent behavior, springs from a variety of sources, and while recognizing that some of these motives, quite beyond the teacher's power to control, will aid or hinder the learner's academic achievement, we continue to promote a program of universal schooling and continue to find substantial evidence of its worth. We appreciate, however, that others must participate in the educational process if the child is to become an effective citizen. The home, church, other professional workers, and community agencies all share responsibility for the education of young people. This must also be true for the education of parents. Perhaps more people should recognize parent education as a part of their fundamental responsibility.

Parent education aims at improving people's performance as parents. Necessary changes in parent behavior can be effected only through a variety of means, since, as Dr. Brim points out, the roots of the behavior originate in a variety of human structures and functions. We should improve our present efforts and bring further research disciplines and teaching skills to the task.

Armin Grams
Associate Professor, Institute of Child Development and Welfare, University of Minnesota.

McFERRAN: *Some questions*

To my knowledge the experiment reported in Jane McFerran's article is the first attempt to use a group approach collaboratively with an individual approach to parents evidencing neglect or abuse of their children, at least the first to reach the literature of social work. [See "Parents' Groups in Protective Services," by Jane McFerran, CHILDREN, November–December 1958.]

In undertaking such a pioneering effort, Mrs. McFerran and her colleagues are to be congratulated for their imaginativeness and urged to continue to test their methods and their conclusions. The evident success of their effort should make us feel that social workers in child-welfare programs have too long been reluctant to utilize group approaches in combination with the individual approach to achieve their treatment aims with their clients.

Mrs. McFerran's article, however, raises certain general and many technical questions that it does not answer. In the first place, it does not make completely clear what the agency saw as the purpose of the use of groups and whether or not the participants knew this purpose. It states: "In such groups the parents would have opportunities to meet others with similar problems, to exchange ideas, and to have a social experience."

In protective service, to a degree greater than in any other child-welfare service, the agency reaches out to neglectful parents with a demand from the community that they change their behavior with respect to their children. In this light does the agency see the group experience as an integral part of its method of helping parents to change? If so, why is its purpose expressed so equivocally?

The article states that no coercion was used to compel attendance, but that visits were made to encourage the clients to come. If the agency had conviction about the value of group discussion to help parents to change their behavior in regard to their children, why is not the same expectation placed upon attendance at group meetings as upon meetings with the caseworker in individual interviews? Or is this indicative of the lack of such conviction?

I do not mean to imply that one article should have been expected to answer all of the technical questions it stimulates, but I wish that it reflected more of the thinking that Mrs. McFerran and her colleagues must have done in carrying on this experiment. Some of these questions are: How were individual couples selected for the group—that is, were there some considered not suitable subjects for the group experiment, and why? Did the leaders' beginning with an agenda, then apparently largely abandoning it, mean that the content changed from an educational to a therapeutic emphasis? Recording, it is said, was considered essential for group evaluation. Was there consideration given to mechanical methods of recording, such as tape, and, if so, were they rejected? Did the caseworker who led the group have any of the members as individual clients? What was the thinking on this point? Could not the same social worker work with the same clients in both individual interviews and group discussions?

In spite of my criticism of her article, I wish heartily to applaud Mrs. McFerran for her willingness to experiment and to expose herself in writing to critical comments.

Kermit T. Wiltse
Associate Professor, School of Social Welfare, University of California, Berkeley.

Author's comments

Our agency is pleased with the thoughtful comments received in response to the article about our parents' meetings. The article was written in hopes of stimulating further experimentation because we believe our experience demonstrated that group meetings are beneficial for some clients in protective service.

In our experiment we considered all clients eligible for this group experience but were selective about the *number* of emotionally disturbed and mentally retarded to be allowed in the groups. (Some of the responses by those participating points up the need for detailed evaluation of this matter of selection.) This was a pilot demonstration and selection was arbitrarily based on a variety of factors after staff discussion. The group process itself also demanded a limitation of numbers.

Although our clients vary in their capacity to form meaningful relationships, they can still work with us to improve their care of children. Frankly, we were not certain how they would benefit from the group experience, but we knew group techniques had been used successfully elsewhere—for example, among mental patients, former mental patients, alcoholics, and parents of handicapped children. Depth of understanding has been noted in some persons who were able to achieve through group experience what they could not achieve with individual help alone. So our experiment was not based on a new principle but is an adaptation.

Our parents were at different stages in the casework process. For some this experience seemed to be primarily therapeutic; for others, primarily educational; and, for still others, primarily social. We considered attendance worth while if the experience was positive in any way.

Although working with a protective-service agency is not completely voluntary, clients still have the right to choose their own methods for improving their care of children. We did not find coercion necessary and preferred to rely on the ability of the caseworker to engage the cooperation of the client about attending. We utilized groupwork as part of the casework process.

Most of the points mentioned by Mr. Wiltse and by Lorena Scherer [See Readers' Exchange, CHILDREN, January-February 1959] had been discussed by the staff or tried out in the experiment. Space here does not permit full reply, but those persons interested are invited to write to the author.

Jane McFerran
Supervisor, Protective Service Division, Jefferson County Welfare Department, Louisville, Ky.

HERZOG: *Researcher and practitioner*

In her article on evaluative research, Elizabeth Herzog provides a valuable commentary on problems of research in the mental-hygiene professions. [See "How Much Are They Helped?" by Elizabeth Herzog, CHILDREN, November-December 1958.] Of special interest to me is her injunction to "include 'intellectually hospitable' research specialists and practitioners on the research team." While such a statement has implications for researcher-practitioner relationships in all types of therapeutic and service programs it has special meaning, I believe, in social work.

The research specialist coming into a social agency has to understand the particular position in which the social-work profession finds itself vis-a-vis the outside community and other professions. Rightly or wrongly, social workers often consider themselves misunderstood by the community. They may be wary of research when such research is brought into being through community pressures. In addition, social workers in their relations with other professions repeatedly find themselves in the role of learners, supervisees, and consultees. Their work and, therefore, their competence is constantly being examined in some way by someone else. This situation has many helpful features, but it also engenders negative feelings. If a research project is instituted for the first time in a social-work agency and this project has as its most immediate purpose the evaluation of agency services, it may be seen by social workers as still another test and responded to accordingly. Strained relations between practitioners and researchers may follow.

Otto Pollak, who discussed this problem at a recent conference on research in the children's field (*Social Service Review*, September 1956, p. 298), suggests that "research before becoming acceptable as a judge of professional performance should first be experienced by social workers as an aid in professional performance."

If we are to build up research specialist-practitioner teams whose members are "hospitable" to one another, it seems necessary that a step to bring about such an experience be taken. In this connection, Miss Herzog's comments on the benefit of pre-evaluative studies take on added importance. For it is precisely in working with researchers on these studies that social workers can have a kind of experience which will result in their perceiving these specialists as helpful colleagues rather than only as "examiners from the outside." This can create a climate in which, later on, proposals for research projects clearly evaluative in intent may be received by these social workers with less trepidation.

Incidentally, in the process of close collaboration with practitioners on such pre-evaluative studies, there is always, of course, the possibility that the research specialist will become overidentified with a particular agency or with social work as a whole which may have some undesirable consequences.

Ralph L. Kolodny
Research Supervisor, Group Work Department, Children's Service Association, Boston.

Guides and Reports

PHYSICAL AND BEHAVIORAL GROWTH; report of the twenty-sixth Ross Pediatric Research Conference. Ross Laboratories, Columbus 16, Ohio. 1958. 104 pp. Free on request from Ross Laboratories.

Verbatim reports of a symposium on child development held under the auspices of the Department of Pediatrics, University of California School of Medicine, San Francisco, in 1957.

SPEECH CORRECTION; the proceedings of the workshop on speech correction in special education, conducted at the Catholic University of America, June 14 to June 25, 1957. Edited by Sister Mary Cyprian Spradling. Catholic University of America Press, Washington 17, D. C. 1958. 172 pp. $2.75.

Included among these technical papers are papers on the speech of the cerebral palsied, the deaf and hard of hearing, the mentally handicapped, persons with cleft palate, and stutterers.

STAFF RELATIONSHIPS AND ATTITUDES IN A JUVENILE CORRECTIONAL INSTITUTION. A monograph based on a study of the boys vocational school at Lansing, Mich. Robert D. Vinter and Roger M. Lind. School of Social Work, University of Michigan, Ann Arbor, Mich. 1958. 61 pp. Single copies free.

An attempt to determine what components of institutional staff, program, and climate effectively rehabilitate delinquent children. The hypothesis and conclusions of this study are to be explored in a continuing study.

PLAY INTERVIEWS FOR FOUR-YEAR-OLD HOSPITALIZED CHILDREN. Florence H. Erickson. Monographs of the Society for Research in Child Development, Vol. 23, Serial No. 69, No. 3. Child Development Publications, Purdue University, Lafayette, Ind. 1958. 77 pp. $2.50.

A report on an effort to learn through play interviews how children feel about and cope with medical procedures involving body intrusions.

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HELPING RURAL YOUTH CHOOSE CAREERS. Edward V. Pope and the other members of the Subcommittee on Transition from School to Work of the Interdepartmental Committee on Children and Youth. Department of Agriculture. Federal Extension Service. Miscellaneous Publication No. 771. 1958. 8 pp. 5 cents.

Noting the decreasing need for unskilled labor on farms, this leaflet advises rural high-school boys and girls of the intense competition for jobs they will face unless they prepare themselves for professional, technical, or skilled work. It points out opportunities for well-prepared rural young people in agricultural and other fields and urges communities to help rural youth prepare themselves for useful citizenship.

HOMEMAKER SERVICES IN THE UNITED STATES, 1958: A NATIONWIDE STUDY. William H. Stewart, Maryland Y. Pennell, and Lucille M. Smith. Department of Health, Education, and Welfare. Public Health Service. 1958. PHS Publication No. 644. 103 pp. 55 cents.

Analyzes data on agencies providing homemaker service, on the homemakers employed, and on the families that received the service.

HOMEMAKER SERVICES IN THE UNITED STATES, 1958: 12 STATEMENTS DESCRIBING DIFFERENT TYPES OF HOMEMAKER SERVICES. Department of Health, Education, and Welfare. Public Health Service. 1958. PHS Publication No. 645. 99 pp. 55 cents.

Illustrates the various ways homemaker services are being provided by the approximately 150 public and private social agencies in the United States that have such programs.

STATISTICS ON PUBLIC INSTITUTIONS FOR DELINQUENT CHILDREN, 1956. Robert L. Rowland. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 48. 1958. 40 pp. Single copies available from the Children's Bureau without charge.

Defining a public training school as a specialized children's institution operated under public auspices and serving delinquent children committed to it by the courts, this report provides statistical data from 108 State and 18 local training schools and 13 forestry camps, and information about their practices and policies. The report is the first one based on data from a newly established reporting system that grew out of the Children's Bureau 1953 study of training schools.

MATERNAL AND CHILD HEALTH SERVICES, 1956. Theodore Pritzker and Thomas H. Smith. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 49. 1958. 30 pp. Single copies available from the Children's Bureau without charge.

This report is based on data collected according to a revised schedule—the first major revision made since national reporting of maternal and child-health services was begun, in 1935. Among the services on which information is requested for the first time are: for mothers, dental treatment and inpatient hospital care; for school children, visual screening, audiometer testing, and dental screening.

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SAFEGUARDING CHILDREN at a street crossing, this member of a school safety patrol is helping to cut down on motor vehicle accidents, the major cause of deaths from accidents among children.

With accidents of all types the leading cause of children's deaths in the United States and the source of an untold number of permanently handicapping injuries, accident prevention was the focus of attention this year on Child Health Day, May 1. Some questions that must be asked in planning a program to prevent childhood accidents are presented in the lead article in this issue.

◀ the authors

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What to consider in planning a program to prevent . . .

CHILDHOOD ACCIDENTS

JAMES L. GODDARD, M.D.
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IN THE PAST TWO DECADES there has been growing concern over the health problems created by accidents and in particular those accidents involving children. Many groups have voiced this concern at various times—pediatricians, schoolteachers, surgeons, parents' groups, national voluntary agencies, and, quite properly, public health agencies at all levels.

Those of us who are part of these groups know one of the major reasons for this concern—accidents are the leading cause of death for all ages between 1 and 35. They have attained this position as the result of the triumph in this century over those ancient enemies of childhood, the contagious diseases.

Thus, accidents have not actually risen to the top of the death cause list. Rather they have been uncovered, as rocks are left uncovered by receding waters at low tide. Like the rocks they are no less real because they have recently been revealed. It is no less our duty to cope with them.

We are not only concerned about the loss of 10,000 children ages 1 to 15 each year through accidental deaths; we are also intimately involved with the problems of children who are crippled, maimed, or disfigured by accidents. The extent to which each of us is involved varies from region to region and depends in many instances on how people obtain health services. The National Health Survey gives us some idea of the dimensions of this part of the problem. Estimates based on the first year of the survey indicate that some 17 million children sustain accidental injuries each year.

Here, further, are some significant details regarding injuries to children:

1. Home accidents are a preponderant source of injury. The motor vehicle is a relatively insignificant factor in this age group.
2. Boys are involved in a disproportionate number of injuries—almost twice as many as the injuries to girls. This disproportion begins shortly after the first year of life and increases thereafter; in the age group 10 to 14 the boys have almost three times as many injuries as girls.
3. The frequency of injury among both sexes is far greater than we had previously estimated. Among males under 15 years, 4 out of 10 suffer some sort of accidental injury each year. Among females, the casualty incidence is 2 out of 10.

There are marked differences between injuries which produce death and those which children survive. The significance of these differences becomes apparent when plans for preventive programs are considered. Analysis of death certificates shows motor vehicle accidents, drowning, fires and explosions, and obstruction and suffocation as the four major accident categories in which children are involved. When morbidity data are examined, falls, cutting and piercing instrument injuries, blows from objects, and animal bites are the major types of accidents to be considered. Motor vehicles are fifth.

Two other sets of facts are worth attention in this

Based on a paper presented at the 1958 annual meeting of the American Public Health Association, St. Louis.

sketchy profile of accidental injuries involving children.

The first pertains to the nature of the injury. An analysis of 7,811 emergency room cases and hospital admissions of children in a northeastern community showed that lacerations, contusions, and fractures are the most frequent types of injuries. Burns and scalds are also frequent in children under 5 years of age.

The second set of facts describes the injuries to parts of the body and according to age group. These reveal that injuries to the head are a major problem in childhood accidents. For the under-1 age group, 6 out of 10 injuries are head injuries.

Even from this limited data we can draw one conclusion—we are dealing with a complex problem which will require us to seek multiple solutions.

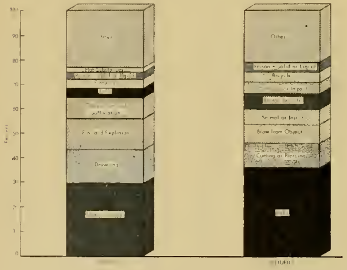
Causative Factors

The causative factors of childhood accidents are largely unknown. There is a belief that we must to a large extent relate these factors to the patterns of growth and development if we are to achieve the understanding necessary to develop effective preventive programs.

The micro-society of the child can be studied through use of the epidemiologic technique. A study of the child will, I am sure, be unproductive if we fail to consider the concomitant stages of growth and development. Any study of the diverse agents involved will be unproductive also if due attention is not paid to their possible interactions with the child. And the environment, whether it be the crib or the expanding universe of the teenager, must undergo systematic scrutiny.

LEADING CAUSES OF ACCIDENTAL DEATHS AND INJURIES

Persons under 15



The first column shows deaths recorded in the United States as a whole in 1956. The injury column is based on data for July 1957–June 1958 collected in one northeastern city.

Above all, our understanding of causative factors will develop only as rapidly as we are able to extend our concern beyond the immediate events surrounding an accident. We must view accidental injuries as the end point of a chain of circumstances and events. This means we must be more concerned with the dynamics of accident causation. We must examine such background factors as training, experience, judgment, and the physiological and mental elements; we must study patterns of operation within given environments and the changes occurring in these patterns of operation.

At this point, a word of caution! Pediatricians, psychiatrists, and other experts in child behavior are beginning to warn us that there may be a definite hazard associated with the efforts to study and prevent childhood accidents. We may, they state, arouse new anxieties in parents which they will transmit to the children. A resulting sense of insecurity among children could increase their accident susceptibility and thus defeat our very purpose to minimize accidents. How then shall we proceed?

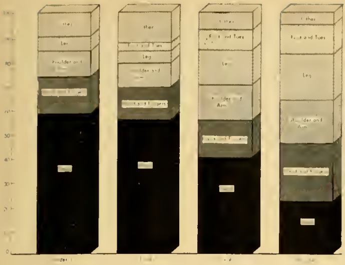
Secondary Prevention

There are two avenues to travel in attempting to reduce death, injury, and disability from childhood accidents. The first is to participate in efforts to ameliorate the effects of accidents. Prevention of deaths from secondary causes and prevention or modification of disabilities are aspects of the problem which cannot be neglected. The virtue of this approach is that often we can produce rather immediate results and perhaps, what is even more important, gain know-how which will facilitate solutions of the more difficult problems posed by primary prevention.

In regard to secondary prevention, three of many activities might be considered:

1. *Poison control.* Rather than dwell on the phenomenal developments that have taken place in the development of poison-control centers during these past 5 years, one may merely ask the question, "Do all the physicians in the community have access to such a center?"

2. *Prevention of drowning.* An important development in the prevention of deaths from drowning is the new method of mouth-to-mouth resuscitation. This



The columns show, according to age groups, the part of the body primarily injured in children treated (July 1957–June 1958) in hospitals in one northeastern city in the United States for injuries suffered in accidents.

method has been proved to be far more effective than the several techniques most of us learned in the past. A good question is: "Are public health workers prepared to teach this method?"

3. *Emergency care.* It has been conclusively demonstrated that the quality and distribution of emergency care for accidents of any type significantly influence the survival rates, length of hospitalization, and degree of disability. The importance of careful handling of the victim from the time of injury until definitive care begins is appreciated strongly by the surgical profession. Unfortunately, the urgency for such care has not always been communicated to those responsible for emergency services. So the question must be asked: "How adequate are the emergency services in the community?"

There are three major elements in this question which should concern the community health agency as much as the practicing physician. They are: (*a*) training of personnel; (*b*) adequacy and amount of equipment; and (*c*) distribution of the service in relation to the population and the facilities used by the population.

Providing positive answers to these questions need not be difficult. More important than detailed solutions and blueprints for action is willingness to accept responsibility for these aspects of community health problems.

Primary Prevention

As all of us concerned with public health move down this first avenue, achieve recognition and support, and clean up these "foci of infection," we will find the means to tackle the problems of primary prevention. There are certain principles which we must keep before us as we undertake this portion of our task. They are five in number: (1) better definition of the problem; (2) education; (3) coordination of activities with other agencies; (4) development of appropriate legislation; and (5) conduct of needed research. The reasons behind these principles are obvious and well understood, but in our anxiety to do something we often forget their importance.

In approaching the total problem of primary prevention of childhood accidents, I would stress to health workers in particular these observations:

1. Without better definition of the problem, we can dissipate our energies.

2. Failure to carry out the needed research will lead to erroneous assumptions. These assumptions in most instances will permeate our educational activities and in most instances lead to failure.

3. Education will be the keystone of success. We will only succeed if we can move from the general to the specific.

4. Legislation in special instances can eliminate or reduce hazards to children. Legislative proposals must be based on facts and be capable of being implemented.

5. Coordination of activities with other agencies and groups will be essential. When you begin to develop program activities for the prevention of childhood accidents, you will run into the problems created by division of responsibility.

Problems can be developed into opportunities by digging in and doing the hard work that will be needed to provide leadership.

A child guidance clinic finds an aid to therapy in . . .

CAMPING FOR THE EMOTIONALLY DISTURBED

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FOR THE LAST four summers, the Tacoma-Pierce County (Wash.) Health Department's child guidance clinic has conducted a camp for emotionally disturbed children. It has, as the following description of the 1958 experience shows, combined a therapeutic emphasis with normal camping activities.

The emotional illnesses coped with most successfully were (1) anxiety states, (2) anxiety hysterias, (3) conversion hysterias, and (4) compulsion neuroses. Many of the symptoms exhibited by children during their evaluation for camp admission were: "lack of confidence; infantile behavior; passive-aggressive behavior; preoccupation with illnesses; tics or habit spasms; fidgetiness; hyperactivity; disorders of speech; and finger sucking." These were reduced significantly in the camp by placing emphasis on: (1) relationship with adults—the camp contained an average of two children per adult; (2) relationship with peers in a small group; (3) consistency in the enforcement of a few necessary rules; and (4) a program aimed at making it possible for every child to achieve some success in physical and creative efforts and in interpersonal relationships.

Because the program has proved in many instances to be an effective aid to therapy it will be offered again this year, though community groups will assume sponsorship, releasing the clinic from responsibility for raising funds for camperships, community interpretation, and financial and business management.

The camp uses the facilities of a YMCA camp located among 140 acres of natural forest on a small cove on Puget Sound. In 1958 it included 48 children—8 cabins of 6 children each, ages 7 through 13, both boys and girls.

Staff Selection

The clinic had learned in past years that the two most important prerequisites for a successful camp program are careful selection of staff and of children. Therefore, in 1958 it recruited 30 percent of the camp staff—all of the senior counselors—from the teaching and guidance staffs of the public schools, on the basis of their maturity, their warmth, their child-oriented training, and their ability to offer wholesome adult identification for the child. Another 30 percent—most of the junior counselors—were outstanding leaders from the regular staff of the YMCA camp, mostly college students. They had the advantage of thorough acquaintance with the physical aspects of the camp, its resources and surroundings, camp songs, camp lore, and campcraft. Other counselors came from nearby colleges and a school of nursing. In addition, the camp employed an arts and crafts director, a waterfront director, and a music therapist. Every staff person was interviewed individually in the child guidance clinic in order to find those with personalities most suitable for the camp objective.

Two psychiatric social workers shared responsibility for providing regular consultation to the staff every evening. One was assigned full-time to the camp. His responsibilities were first of all to be available for "on the spot" consultation with staff or for direct intervention with children experiencing an emotional crisis. Secondly, he was a program consultant to the camp director. The other psychiatric social worker lived in camp but worked in the clinic during the day and was the liaison staff person between clinic and camp. The clinic's psychiatrist spent a day and an evening in camp consulting with the staff.

The camp coordinator and director was a teacher in charge of guidance in a junior high school who had been at the camp in the same capacity for several years. His responsibilities included: developing the program in consultation with the social worker; coordinating staff activities; making assignments to the staff; and coordinating activities with the business manager, who was responsible for supplies.

The Children

In selecting children for the camp, the clinic was guided by past experience, which indicated that the child with symptoms such as shyness, infantile behavior, lack of confidence, fears and hypochondriasis seemed to benefit most visibly from the camp experience. This, we believed, was due to the milieu therapy and a ratio of staff to children which made individual child-adult and child-child relationships feasible.

Experience has shown that children exhibiting symptoms of aggression and hostility were able to benefit from the camp experience if the ratio was controlled—one, or at the most two such children per cabin. Such children presented a considerable strain on the counselors as well as on their cabin mates. We had also learned that children who had difficulty in expressing hostility seemed to benefit by association with an aggressive child as long as sufficient and consistent control was maintained.

On the other hand, we had learned that children who acted out severe aggression in antisocial behavior were not suitable for our camp because of their driving need to test the camp's staff repeatedly to the point that they required continuous attention. Other children not accepted were those whose contact with reality or amount of intelligence was not sufficient to enable them to comprehend and follow the camp's safety rules.

Children were referred for camp by child guidance clinic therapists, as well as by public health nurses, social workers of other agencies, ministers, physicians, the children's service of the State hospital, and other child guidance clinics in the vicinity. Some parents read in the local newspaper about the camp or heard about it from friends and applied to the clinic directly for camp admission. Procedurally, a child applying for camp was evaluated in the same way any other youngster applying for child guidance services. But in the evaluation, we paid special attention to whether the child's emotional needs were of a type likely to be met in a camp setting.

Preparation

Once the children were selected, the next step was to divide them into cabin groups of six, taking into consideration a variety of factors. Since our aim was to form a cohesive group—mental age was of more importance than chronological age. We considered a balanced group to be one including one or two youngsters exhibiting a tendency to dominate and be aggressive; several whose major problems were shyness and withdrawal; perhaps another with hypochondriacal preoccupation, fears, and phobias; and one with a great need to be accepted.

With this type of balance, the children could, with the help of the staff, interact with each other for their mutual benefit. The group process seemed especially helpful to the shy, withdrawn youngster, who with some understanding of the behavior of his aggressive cabin mates as well as his own, became able to assimilate some of the aggressive behavior he observed; but the reverse was also true to a more limited extent.

From the second year on, we placed a senior and a junior counselor in each cabin of six children. During our first year, we had one cabin counselor per six children in addition to the auxiliary staff. The children were not able to form the adult identification at which we aimed and the counselor was too exhausted from the many demands, emotionally as well as physically, placed upon him. Additionally, our nightly staff development programs did not function satisfactorily.

Once the cabin groups were selected, we arranged for the groups to meet in the clinic prior to camp so that the children would get to know each other. In 1959 we are carrying this arrangement one step further. The two counselors are meeting with their respective cabin groups so that the children not only learn to know each other, but also meet the adults with whom they are going to live.

The meetings provided an opportunity for the clinic staff to test their hypothesis that the children in each group would derive a therapeutic benefit from living together. The meetings also gave the staff a chance to spot and withdraw from the plans the few youngsters who were too uncontrollable and disruptive to fit into the camp program. Because of this precamp observation, we found it necessary in camp to move only a very few children from one cabin to another.

While the children met in groups at the clinic, the mothers met there at the same time. Thus they had an opportunity to raise questions, get answers, and, to some degree, learn to deal with their anxieties regarding camp. The attitude of some overprotective mothers in these groups was very revealing of some of the reasons for the child's difficulties. The group was frequently able to offer some relief to the mother's anxieties.

Inservice training for the staff started in camp 2 days before the arrival of the children. Its main purpose was for each member of the staff to learn the role of the other members and to learn to function as a member of a team focusing upon the emotional needs of the children. The training sessions described clearly the lines of authority but, at the same time, emphasized the point that the success at camp depended on each individual's contribution. The purpose of the camp's nightly staff meetings was defined not as critical evaluation of one another's work, but as exchange of ideas in an atmosphere conducive to a free discussion of problems.

The social worker who led the discussion in these training sessions, as in the ensuing nightly staff meetings, encouraged an atmosphere where positive and negative feelings could not only be voiced but were also considered essential toward growth and understanding. He helped the counselors see that because they would be living with the children, they would be more real to them than the clinic's therapist. The social worker also spent the last half day of the training in individual sessions with each senior and junior counselor to acquaint them thoroughly with the problems and needs of each of their children, making some suggestions about how to meet them.

Program

The program was designed to increase maturity by cabin group discussions and psychodrama—which provided outlets for hostility as well as opportunities for insight—by the development of group cohesion, and by finding success through a variety of media. Its activities did not differ greatly from that of a regular camp. The main difference lay in the greater amount of time the children spent with their own cabin groups. However, interwoven in all the activities were the elements of interpersonal relationships and ego-building goals. For example, a poorly coordinated youngster was given sufficient help by one of his counselors to be able to row a boat and so to experience the feeling of mastering a physical activity.

All activities were permeated with meaningful relationships with adults who not only enabled each child to find success in something, but who also provided him with an opportunity to find acceptable outlets for drives which needed to be expressed. For example, the arts and crafts director encouraged some of the shy children to build simple musical instruments. The music therapist then formed a rhythm band, thus helping the children to use a medium of expression to find success.

There was no organized competition in camp except for daily cabin inspection, when recognition was bestowed upon the neatest cabin. There were a few camp-wide programs—trips to nearby islands or other points of interest, swimming, a "Pirates Day." Other activities included fishing, boating, hiking, ballplaying, cookouts, and overnight campouts.

A rest hour after lunch was often used for cabin discussions with the purpose of helping the children to participate in the give-and-take of daily life and to learn to cope with some of the problems which always arise when people live together.

These cabin discussions focused on such questions as: "Why do some youngsters not care to take part in an activity? Is there some way for us as a group to enable them to participate? What shall be done with the youngster who does not clean up his bunk so that the cabin gets a reprimand during inspection?" Usually these discussions were guided to some degree by the leaders in efforts to: (1) deal with reality problems facing the cabin group as well as the individual; (2) create more understanding in the children of themselves and others; and (3) increase group cohesion.

Each child served on one of three camp committees, which met every other day—a camp government council, a campfire committee, and a religious services committee. Each committee had two staff advisers. The committees' purpose was to give the children a voice and a role to play in camp, and also to expose them to democracy in action. Special efforts were made to enable the shy children to contribute to the committee discussions.

The camp government council discussed such subjects as camp regulations pertaining to water safety and how to deal with offenders. Occasionally, the children complained about the rules. Some of their complaints were realistic, but in the discussion the children often expressed their personal needs of either supporting or siding against authority. We believed that the children benefited from listening to several sides of one issue and observing how a decision was based on the interests of the majority. Such discussions produced valuable data for the clinic records as well as subjects for future cabin discussion.

The campfire committee planned the programs for the nightly get-togethers around the campfire—singing, storytelling, skits, and acrobatics. One of the members was Paul, a scrawny little 8-year-old boy with large thick glasses, who at times had great difficulty with his speech. Diagnostically, he had impressed the clinic as suffering from a neurosis affecting his conception of himself, his control of elimination (he was a bed wetter), and his social adjustment. One afternoon, at the committee meeting, he volunteered to be the master of ceremonies for the campfire that night.

Paul did a wonderful job that night and from then on became very active in the campfire programs, having found in them a source of satisfaction and recognition. His enuresis decreased and his relationship with his peers improved markedly. A former need to associate with adults decreased as he found these other satisfactions. Paul's mother, still a participant in a group therapy project in the clinic, seems to have been able to sustain his progress.

The senior and junior counselors met on alternate evenings for 2 hours with the psychiatric social workers, the camp director, the music therapist, the arts and crafts director, the nurse, the waterfront director, and on one occasion with the psychiatrist. There, each counselor reported on his six campers, the progress they made, the problems which arose during the day and the night before; and the group helped the counselor to develop plans and ideas which would bring further gains for the camper. For example, at one meeting a counselor, rather embarrassedly, told about being asked by two of his 8-year-old boys to kiss them goodnight. Then, another counselor related an identical experience. In the ensuing discussion a few counselors seemed to consider such requests "unmanly" and were doubtful about how to handle them, but as the pros and cons were considered the two counselors involved developed enough ease to be able to deal with the children's request in a positive manner.

In other discussions the group helped certain counselors to accept campers who had enuresis or soiling problems and at the same time developed ideas

A rhythm band (left) and two anglers (right) at the Tacoma child guidance clinic's camp for emotionally disturbed children. The camp, attended largely by shy, withdrawn children, stressed activities through which the children could experience a sense of success or take their first tentative steps toward companionship without the risks of competition.

on how to deal with the feelings of other campers regarding these problems.

The precamp medical examination showed very few children actually in need of daily medication except for those for whom sedatives, tranquilizers, or anticonvulsants had been prescribed. Nevertheless, some hypochondriacal children of overprotective mothers arrived in camp with assortments of patent medicines and rigid directions from their mothers about taking them regularly. Very gradually, as the camp experience met more and more of their needs, the interest of these children in taking medicine subsided, in some to the point of forgetting about it completely.

Signs of Improvement

Milieu, program, and interpersonal relationships were the therapeutic tools of camp. Three examples demonstrated their effect:

Tom. Tom, a 10-year-old, and his parents had been receiving treatment at the clinic for 4 months before he came to camp. He had been referred to the child guidance clinic because of vomiting attacks without organic cause for 3 years and with a history of showing no normal aggression. In the clinic he impressed us as a fairly anxious boy who was not able to relate to others easily. The therapist found him preoccupied with fantasies of aggression toward his brother, involving various unpleasant, dangerous, and destructive activities, but full of anxiety about his own aggressive impulses.

At camp Tom was at first very reserved and reluctant to participate in any aggressive activities. On the fifth day, he began to take part willingly in nonaggressive games and seemed to want to please the counselors in every way. On the eighth day another youngster selected him as a target for his aggressive needs. Tom asked his counselor whether he could fight back. He was given permission to do so and proceeded, upon the next provocation, to get involved in a regular fight. He won, and from that day on began to show leadership qualities. He accepted responsibility well and identified closely with the counselor, supporting him in all issues and keeping very close to him. He still would not participate in aggressive games.

The full-time social worker was also Tom's therapist in the clinic and was aware of the boy's difficulties with his aggressive feelings. In subsequent interviews with Tom and his parents, the social worker learned that Tom had had a 3-day vomiting spell shortly after his return home and that he had not told his parents about his fight because he thought they would disapprove of it. His feeling about the fight kept the focus of his treatment hours upon the acceptance and eventual control of his hostility, with good progress.

Richard. Richard, age 7½, had also been in treatment at the child guidance clinic before going to camp, as had his father and mother. He had been referred there by his school because of poor school work, infantile behavior, lack of interest, lack of bowel control, and withdrawal. Although Richard had been born prematurely—in the seventh month of his mother's pregnancy—complete physical and neurological examination at the time of his admission to the clinic revealed no abnormalities. Psychometric tests showed him to be functioning on the level of dull-normal intelligence. Richard's mother showed evidence of being greatly overprotective and also somewhat overcome by the responsibility of raising a second child. His father, a professional man, who had been studying at night for many years, seemed to be a very dominating person who nevertheless harbored deep feelings of insecurity and anxiety.

The decision to send Richard to camp had been based on the hope that the therapeutic milieu would stimulate his emotional growth and provide him with opportunity for masculine identification.

At camp Richard at first asked questions continually and at times wandered around seeming not to comprehend what was going on. In the relations he had with the other campers he was never more than a follower. Often he embarked on little isolated projects with paints or clay. However, as he probed his new environment and witnessed his counselors' permissiveness and consistent discipline, he was increasingly able to express directly some of his hostile and destructive wishes.

Opportunities to act out a feeling without suffering consequences were therapeutic for Richard, since at home he did not have them. Slowly, his fear of human contacts and his disbelief in his capacity to achieve gave way to an ability to develop a degree of relationships with other children and to a willingness to test and explore new activities such as fishing, boating, and playing in the water. Throughout the 12 days, he was required to follow the camp rules consistently. Though he was at first very slow in such activities as setting the tables in the dining room, cleaning the cabin, or taking a shower, he soon showed that he knew that certain procedures were expected of him and the others, and that he could comply.

Not only were considerable therapeutic gains made with Richard at camp, but the knowledge secured through observation of him there was invaluable to the clinic in planning further work with him and with his parents. It was also of great help to his classroom teacher, with whom the clinic held a conference at the beginning of the next school term.

Garry. Thirteen-year-old Garry, whose chief problem was lack of impulse control, had had no treatment at the clinic before going to camp, having been referred by the school at the end of the term. He was the younger of two brothers. Their father, who had always rejected Garry, had died years previously. Their mother required continuous bolstering, emotionally and economically, in order to be able to keep the family together. At camp Garry at first tried to present himself as a successful youngster without any problems. On the second and third day, his difficulties came out in the open when he began bullying, refusing to participate in cabin activities, and making jokes of the program. His reaction to discipline was loud and boisterous joking, and only after testing the counselors' patience to the limit would he meet social demands.

For the first 6 days, Garry was a serious strain on his cabin counselors and a poor influence on another boy who had similar problems. Then an opportunity for dramatic intervention in his personality problems presented itself when his cabin group and others went on a 2-day hike. While climbing a steep, rocky mountainside, Garry, when nearly at the top, suddenly froze and refused to move. He became very agitated and fearful of falling, cried, and called for his mother. Instead of the loud, boisterous bully, he was a little boy afraid. The psychiatric social worker stepped in immediately to help Garry to control his fear and later used this incident to help him with his perpetual feelings of inadequacy. Garry was never again the same bully in camp, except for very brief periods. His cabin group did not allow him to continue the role.

A great deal of communication took place between the social worker and the leaders of Garry's cabin group in order to coordinate their efforts in his behalf. Garry is now attending the clinic and responding well to treatment, but without the opportunities and understanding provided by the camp experience the prognosis would have been less hopeful than it is.

Followup

The counselors wrote reports on each camper. This material, together with the social worker's observations, was used in clinic conferences with the parents of each camper after the camp closed. In these conferences the parents were informed of their child's adjustment in camp as well as of his continuing needs. Complete camp reports were also sent to the referral sources.

A few children attended camp without receiving any treatment either before or afterward. Others continued treatment previously begun with the guidance clinic or with the referring agency, such as the school counseling division or a family agency, the clinic providing consultation service and a report of the camp observations. Some children who had had no prior treatment anywhere revealed a great need for treatment through their behavior at camp. The clinic has, with some success, attempted to stimulate their parents to secure the needed treatment for them either at the clinic or elsewhere.

Our experience has indicated that to be successful such a camp requires coordination with the referring community agencies and services to whom the child might return for further treatment. This not only helps the child, but also gives the referral sources an interest in the camp and a willingness to participate in the annual camp planning and preparations.

An important by-product of the total camp experience is the philosophy and understanding the counselors develop while at camp. This understanding is passed on, in varying degrees, by the individual staff members to their students if they are teachers or school guidance personnel, or to their classrooms and into their future professions if they are college students.

Immature adult behavior and a shirking of responsibility toward youth has provided much of the confusion that disturbs the juvenile—who has a much better right to be immature.

New England Journal of Medicine, *September 25, 1958.*

A PROGRAM TO PREVENT RHEUMATIC FEVER RECURRENCE

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CLINICAL OBSERVATION indicates that this country is experiencing a decline in the incidence and severity of rheumatic fever, a trend associated with and probably closely related to the rising standard of living of most of our population. Nevertheless, this disease—whose most frequent victims are children—still represents an important public health problem. Though less prevalent now than formerly among those whose living conditions are good, the incidence may well be as high as ever among indigent or marginal income families—those who live under crowded, unhygienic conditions which promote the spread of streptococci—the very people who, when handicapped by illness, put the greatest demands on the community for support.

This is particularly true in urban areas where large groups of people live in congested slums. Because this population is unstable and moves frequently, followup is difficult. The people in these areas generally obtain their medical care through clinics, or in cases of emergency from practicing physicians most of whom do not attend medical meetings, read medical journals, or have teaching hospital appointments. These people tend to shift from one clinic or physician to another. They have little concept of health as a positive attribute, and seldom consider payment for health supervision to be a justifiable expense. They are difficult to reach through health-education programs. But they are the people whose children produce the largest number of cases of rheumatic fever in metropolitan areas today.

A city has a greater variety of resources for reaching this difficult group than is commonly found in the small town or rural area. It has organized school health services through which cases can be found; clinics, often under medical school or heart association auspices; numerous voluntary health and welfare agencies providing a wide variety of services. It has a lay and professional population representing many talents which can be called upon to provide leadership in program development.

However, the very existence of many agencies creates special problems. Coordination of agency services is necessary and difficult. Effective communication, relying as it must largely on forms and other written material, is difficult to achieve. But without close integration of services and effective interagency communication it is all too easy to lose sight of the individual for whom the program is planned.

Urban Programs

An urban program will prevent the greatest number of recurrent attacks of rheumatic fever, if it concentrates its efforts—at least in the beginning—on the *indigent* who obtain medical services through clinics and other public services, and on those of *marginal* income who attend pay clinics, or receive private physician care for acute illness, but who cannot afford on a long-term basis the drugs and frequent medical supervision required if recurrent rheumatic fever is to be prevented. Patients in these groups are readily found through organized school health services and through hospital and clinic admissions.

The elements of a program which will reach these groups are:

1. ***The cooperation and understanding of the staffs of all the agencies involved,*** and of the practicing physicians who care for this segment of the population. These agencies include the local heart association (often assuming the leadership, alone or jointly with the official health agency), the depart-

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Based on a paper presented at the 1958 meeting of the American Heart Association in San Francisco.

ments of health, welfare, and education, municipal and voluntary hospitals, voluntary health and welfare agencies of various sorts, and the local medical societies.

Such understanding and cooperation can only be obtained by:

a. *Joint planning* of the program by representatives of all the agencies to participate in it.

b. *A continuing education program* which includes all professional groups concerned, from the practicing physician to the classroom teacher. An educational program cannot successfully be a one-shot affair, particularly in a large city. The practicing physicians involved are difficult to reach. Agency professional staffs change and program procedures are complicated. Unless plans for continuing educational efforts are built into the prevention program from the start, procedures are forgotten, children become lost to followup or do not receive indicated services, and the program grinds to a halt.

2. ***Diagnostic services.*** These are essential in any prevention program focused on clinic patients or on those of the private physician. The difficulties inherent in the diagnosis of rheumatic fever, or of heart disease in children, lead to overdiagnosis more often than to the missing of cases. Unless diagnostic and consultation services are available as part of the program and, more importantly, used, children who have never had rheumatic fever will be registered on the program and receive prophylaxis. A false label of rheumatic fever and rheumatic heart disease, so often resulting in unnecessary restriction of a child's activities to the detriment of his social and emotional development, was serious enough in the past; but now with the possibility that a child so labeled may be placed on indefinite drug prophylaxis it is even more serious.

A consultation service, besides clarifying individual diagnoses, serves as a source of referral to clinics or private physicians of cases not under medical care found by the school physician. It can also serve as an educational tool for the school physician and the practicing physician, and assist the latter in obtaining community services for his patients.

3. ***A good outpatient clinic program.*** Such a program will reach the majority of rheumatic patients in many urban areas. But a good clinic prevention program demands hard work and is often costly. It involves specific planning and, often, reorganization of the usual pediatric or cardiac clinic if it is to be effective. Patients will need to be seen more often (at least once in 3 months probably) than is usual for symptom-free patients. This usually requires an increased medical staff, or longer doctor hours. Successful followup requires clerical staff and sufficient social work and public health nursing staff. The never completed but essential education of patients, which taxes the ingenuity of all professional staff, must be carefully organized.

The reorganization and expansion of a clinic's services, necessary for effective rheumatic fever prevention, require enthusiastic medical leadership in the clinic, good clinic administration, an adequate staff, and the wholehearted cooperation of the administration of the hospital.

4. ***Drugs within the financial means of the patient.*** Whether a patient is cared for in a clinic or by his private physician, prophylactic drugs must be available to him within his ability to pay. A number of different ways in which free or low cost drugs can be provided have been developed in different communities. This of course is an important aspect of any program but is sometimes overemphasized in the development of prevention programs, at the cost of too little attention to case finding, adequate and continuing medical care, education of patients, and followup.

Too often the provision of drugs has been the major aspect of programs to prevent rheumatic fever. Prophylactic drugs are wasted, from the point of view of secondary prevention, if they are consumed by a person who has never had rheumatic fever. They are ineffective as a means of preventing streptococcal infections and recurrent rheumatic fever in persons genuinely rheumatic if they remain in the container in which they are dispensed—where they often do remain in the absence of a good education and followup program!

Moreover, physicians' (and probably patients') preference for the more expensive oral penicillin, instead of the apparently equally effective sulfa preparation which can be obtained at a fraction of the cost, has exaggerated the financial difficulties in the provision of drugs. It is a rare family who cannot afford the cost of two sulfadiazine tablets a day. As a rule, for patients of marginal income the financial problem is less the cost of drugs (important as that may occasionally be) than it is the cost of regular visits to a physician, without which few patients remain continuously on any prophylactic regimen.

5. *Special prophylactic clinics.* Urban communities might explore the possibility of setting up such clinics specifically for the marginal income patients of practicing physicians. These clinics would be for prophylaxis only, the patient remaining under the care of his own physician for everything else. The clinics would provide drugs and the necessary health education and followup services to ensure continuous prophylaxis. They should be as acceptable to the practicing physician for patients at this income level as are well-baby stations, child-health conferences, and health department immunization services.

6. *An organized followup program.* This is the key to an effective rheumatic fever prevention program. Clinics, in spite of their own followup procedures, often fail to get patients to keep appointments, or lose track of them altogether. The practicing physician usually has no followup system at all; he cannot require periodic return visits, he can only suggest them. In New York City the health department has been sending followup questionnaires to physicians of patients for whom prophylaxis has been recommended by the diagnostic service. Time and again these questionnaires are returned stating "patient not on prophylaxis," with the reason checked "patient did not return" or "patient uncooperative."

Program followup may be carried out through the school health service and its public health nurses, or directly by the public health or visiting nurse through a system built around failures to have drug prescriptions filled after the expected interval. But whatever the system, good followup is the key to a successful program, and in most instances the public health nurse is the key to followup.

A word should be said here about the followup of adolescents, particularly in a city relying to any extent on a clinic program. Unless special plans are made to meet the unique needs of this age group, preferably through the establishment of their own adolescent clinics, many of them will be lost to followup on transfer from a pediatric to an adult clinic—at a time they are in need of many services, and the danger of rheumatic recurrences is by no means past.

7. *Administrative agency.* Finally, a prevention program must have a responsible, strong, administrative agency, preferably within the health department, to coordinate all available community services for the benefit of the individual who needs them.

It is the administrative agency to which cases found through any source are reported; which is responsible for keeping track, by means of a case register, of the individual child as he moves, shifts treatment agency, or disappears, as often happens in a large city; which sees that medical care, drugs, and other needed services are available to him.

The administrative agency, through its contacts with service agencies about the problems of the individual child, becomes aware of those areas where special educational efforts are needed, where duplication of effort is taking place, and where agency responsibility needs clarification. It is in a position to determine gaps in service and to stimulate the community to provide the missing services. Through its case register, planned to produce the information needed, it is responsible for frequent periodic evaluation of the program itself.

Conclusion

Although a secondary prevention program in a metropolitan area will reach the largest number of cases soonest if it aims first at the children of school age of lower-income families, it should not, of course, be limited to this group. As the program develops efforts should be made to find all children in the community with a history of rheumatic fever and to make available to them all the services of the program, and to extend the program to adults.

Nor should a secondary prevention program, particularly in an urban area, be limited to the prevention of recurrent rheumatic fever. It is dealing with individuals most of whom are also in need of services other than the prevention of rheumatic fever. Indeed, some of their needs will be the direct result of our preventive efforts. The necessarily close followup and daily medication or monthly injections are likely to produce emotional problems in both the patients and their families, which will need careful handling, and not infrequently specialized services. Some of these children, despite our best efforts, will have varying degrees of heart disease. Some will need special provision for their education—others will need specialized vocational counseling and training. Many will need assistance in the solution of social and economic problems. All will need close, good medical followup.

Plans should be made from the start to use the prevention program as the framework for a comprehensive community program which will find, follow, and ensure all needed services to all children and young people with rheumatic fever or with heart disease, either rheumatic or congenital.

A psychologist looks for ways to hurdle the obstacle of . . .

VALUE CONFLICTS IN TREATING DELINQUENTS

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IN RECENT YEARS, the problem of values has become a critical issue in psychotherapy, casework, and counseling. Values—goal-oriented attitudes arising out of personal and social experiences leading to judgments of behavior as being right or wrong, desirable or undesirable—permeate all human relationships. They are crucial in the treatment relationship.

No matter how one approaches treatment objectives—whether directly, rather indirectly, or passively—the values of the therapist, consciously or unconsciously held, become operative influences in the treatment process. In treating juvenile delinquents, whether in a court, institution, or nonauthoritative setting, values are of the essence, since the client's antisocial behavior runs counter to the values of the community as expressed in its laws, and often to the less formally defined values embodied in social and moral codes.

Treatment can scarcely move forward constructively if there is no coming to grips with value conflicts, not only in recognizing them when they occur but also in finding ways of dealing with them. This necessitates an understanding of the values operative in the lives of the delinquent, on one hand, and of the therapist, on the other, as well as some clarification of goals.

Sources of Values

Of course, values are not spontaneously generated; they are generated from the individual's own experiences and those of the group in which he is reared.

Probably the most potent value-bearing influence affecting the individual is what has been referred to by the Gluecks as "the under the roof culture"—the family.[1] Parental attitudes toward life and society begin very early to shape the goals, ideals, attitudes, and values of the child. In the family are fused various degrees (or distortions) of cultural, national, racial, and religious standards which in many ways govern the family members' expectations. While individual families differ, various subgroups within our social structure exhibit differences in attitudes toward property, chastity, and expressions of feeling and other types of behavior. Because many delinquents come from lower socio-economic groups, the therapist in working with them must fully appreciate that the prevailing attitudes toward schools, jobs, religion, recreation, friends, sex, personal hygiene, clothing, adults, and authority vary considerably between underprivileged and well-to-do neighborhoods.

As opposed to the middle-class orientation toward long-range planning and the deferment of immediate gratifications in attaining goals, values in lower socio-economic groups are apt to emphasize short-term objectives.[2] For many persons of lower socio-economic status, the struggle for survival dictates emphasis on success in meeting immediate stresses in living without looking toward a rather abstract future. An understanding of this makes it easier to appreciate, although not to condone, such attitudes among delinquents of low socio-economic status as "It's all right to take it if you don't get caught" and

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The author presents the views expressed in this article as his own and not necessarily as those of the agency with which he is connected.

"It's all right to walk off with it if it's unattached." Such attitudes are reinforced in underprivileged groups by a low capacity to gratify desires created and constantly stimulated through the general culture's omnipresent advertising apparatus and other culture vectors.

A recognition of the existence of value conflicts will help little unless the therapist has a clear conception of both the ultimate and immediate goals of treatment. He has to be clear about the relation of immediate to ultimate goals when such concrete questions arise as: What does a boy wear for a job interview? Should a boy who expects to be a truck-driver finish high school? Or how should a girl act on her first date?

Conflicts in Goals

The problem becomes even more acute when it calls for a resolution of value conflicts within the therapist's (or the agency's) own conception of the purposes of treatment. For instance, practitioners have observed among some delinquents that the giving up of delinquent behavior may be followed by compulsiveness, phobias, and other neurotic or psychosomatic symptoms. This happened to Harold, a 14-year-old boy, who had been involved in several minor thefts and fights. Initially he had appeared independent and hostile, and spoke with but a slight speech impediment, but after 2 years of intensive psychotherapy, during which he discontinued his antisocial behavior, he developed a pronounced facial twitch, stammered embarrassingly, and became somewhat hypochondriacal.

With some delinquents, giving up a gang affiliation may mean surrendering their only human contacts. For example, Earl, a peripheral member of a gang, became so isolated and self-absorbed in the 8 months after he dropped the gang that serious concern was aroused about what had been accomplished in treatment. Since the boy was marginal, intellectually, emotionally, and socially, the gang's tolerance of him had been one of his few ties to reality. Treatment did not seem to be successful in replacing this with any stronger tie.

Such situations confront the therapist with the necessity of making very delicate decisions. How can he resolve such symptom-exchange complications? What issues must he carefully weigh in the balance? Assuming that the therapist can foresee eventualities like this, the course of action he follows cannot be prescribed automatically. It seems evident, however, that the therapist must measure his estimate of the amount of personal damage to the patient or client that might result against the potential social damage. In any case, I believe that in regard to delinquents the important criterion is the degree to which antisocial behavior is diminished.[3]

Some Treatment Problems

From the point of view of treatment, the problem of values makes itself felt in two ways. On the one hand, the therapist must be able to sort out the confusions and contradictions of the differing standards facing each client. Unless he can do this, he may gravely impair the progress of treatment by misinterpreting the significance of the client's reactions. Thus, for example, he might mistakenly regard a young delinquent who maintains his hostility toward middle-class authoritative adults, including the therapist, as sick and therefore requiring intensive psychotherapy and fail to perceive his sound emotional and intellectual resources.

On the other hand, and probably of much greater significance in the dynamics of treatment, are the values explicitly or implicitly accepted by the therapist and reflected in his techniques. In this connection, it becomes essential that the therapist recognize the ways in which his value system may differ from the delinquent's because of differences in background, orientation, and life experiences.

Since many professional workers have middle-class orientations and living patterns, they tend to act in conscious or unconscious accordance with middle-class values. Indeed, even for the most competent professionals, class values that become merged with living styles achieve such potency as ideals and status symbols that looking at them with objectivity is extremely difficult. This suggests that often the therapist's middle-class values are built into the determination of treatment goals. While such goals may be appropriate for youngsters who come from a cultural background similar to the therapist's, they may not all be appropriate for a young person from a different socio-economic background.

However, in conceiving *long-range* goals the clash in values between the middle-class therapist and the delinquent of low socio-economic status may not create much real difficulty. After all, both the therapist and client generally accept the notion that therapy is intended to help the delinquent. Furthermore, since long-range goals are projected into the future, the delinquent tends not to become too concerned about them. Characteristically he is more concerned with meeting immediate problems. Goal disparities become much more acute in relation to the short-range day by day objectives which develop in treatment.

A value problem arose for a therapist who was treating Connie, a physically matured, 17-year-old delinquent girl, when Connie announced that she was about to marry a sailor whom she had known only 2 weeks and who was scheduled to ship out soon. In the light of the girl's obvious charm and intelligence, and the shortness of the acquaintance, the step seemed tragic to the therapist, but from Connie's point of view it seemed to be the best way to escape from a near psychotic mother and a sadistic, sexually forward stepfather. Actually the marriage worked out well.

Examining Assumptions

An examination of some traditional assumptions regarding treatment methods seems warranted. Time-honored practices in regard to confidentiality of information, recordkeeping, environmental manipulation, and sharing information with the client, for instance, may require modification in treating juvenile delinquents. In a New York agency which works with gangs, recognition of the need for some changes has resulted in the establishment of explicit criteria for guiding workers in reporting to the police such dangers as the use of narcotics, possession of firearms, and impending or actual gang battles. The need for immediate action in relation to a client being brought before the court might also require a prompt decision by the worker, without consultation with the client, on release of information to the authorities.

In the therapist are merged all of the value pressures forced upon the treatment relationship from the outside. If he is in an agency he not only brings to the therapeutic relationship his own set of values, but he also mediates the values of the agency's director, and board, and the community. For example, when a young delinquent acts out his conflicts aggressively in the agency's office or waiting room by loud yelling, banging away at an expensive typewriter, tinkering with the dictating machine, pocketing small objects, or disarranging pictures and shelves, the therapist's own attitude might be well attuned to the youngster's treatment needs, but the agency's administrator might not appreciate the therapeutic necessities and insist upon limitations which would circumscribe the therapeutic possibilities. In handling such a dilemma, the therapist had best be clear about the respective apportionments of permissiveness and of limit setting in treatment.

Agencies dealing with delinquents should be prepared for actional possibilities so that too much limit setting does not occur. The techniques developed by Redl and Wineman in an institution for seriously disturbed delinquents could be examined profitably in this regard.[4] The worker would also do well to anticipate acting out on the delinquent's part and, to the extent possible at the level of the therapeutic relationship, let the client know what is and what is not allowed before he actually does any damage. When Joe stole a dictating machine from the agency's office as a declaration of independence in the face of a deepening of his relationship with the therapist, the agency's administrator took a rather dim view of the therapist's assertion that progress was being made.

It seems clear that the view that the therapist must see himself functioning as a professional solely on behalf of his client needs some modification. For instance, if the therapist realizes that a client's strong destructive or self-destructive drives are fairly close to enactment, should he not let some other qualified persons, at school, in a recreational agency, or elsewhere, know so that preventive measures might be taken? Surely, a boy with overwhelming psychosexual difficulties could be steered away from such sexually stimulating situations as being left alone with a much younger girl or cast in a role certain to inflame his sexual fantasies. Certainly, departures from rigid confidentiality, even when strictly in the client's own interests, should be based on a prior understanding with the client, whenever possible. But when not possible, and the client or the community needs protection, what then? A reconceptualization of some formal ethical principles may be necessary, with the resulting hypotheses subjected to validation. The recently issued report of the National Social Welfare Assembly's ad hoc committee on confidentiality is a stride in this direction.[5] [See CHILDREN, September-October 1958, page 195.]

A Look at Techniques

Orthodox treatment techniques, which flow from assumptions that may be valid for middle- and upper-class clients, seem also to require alteration to be effective for socially and economically depressed persons. Such techniques as remaining passive and not becoming involved in the client's day to day problems have been derived from these assumptions, as have such practices as keeping interviews to tight time limits and insisting that all interviews be held in the office. In working with a delinquent, such practices often result in loss of the client to treatment.

When Julian told his therapist that he was going out directly to steal an airplane, he would undoubtedly have either successfully flown away or killed himself trying if the therapist had not hastily trailed him to an airport and physically grappled with him beside the cockpit. Incidentally, this experience turned out to be the beginning of Julian's real involvement in treatment.

The delinquent most frequently is an especially resistant client, not merely because of inner motivations but also because of his immediately pressing concrete problems such as court appearance, physical danger, or the necessity to find a job. Such problems cannot await a detached, time-consuming, verbalistic approach. Moreover, talking to the therapist can to him seem too much like "squealing." Then too, the words of the therapist, unless artfully selected in language the delinquent understands, can sometimes increase his mistrust and confusion.

Another difficulty in treatment may arise because of a failure to realize that what middle-class, college-trained practitioners consider to be ordinary logic is not so perceived by many disadvantaged persons. This is not necessarily due to a lack of intelligence, but rather to a loss of interest when cause and effect relationships become complicated by numerous intervening variables. The threat of immediate demands is too great to permit such persons the luxury or anxiety of waiting for some future benefit.

Treatment of such clients is not an unalloyed, antiseptic process. The therapist working with delinquents invariably runs up against situations in which he must put himself out to a considerable degree. He must be prepared for a string of latenesses or broken appointments, calls from or to lawyers and probation or parole officers, appearances in court, visits to prison, efforts to help the client get a job or into a special school, and emergency calls at any hour.

Unfortunately, many trained therapists avoid working with adolescents, and particularly with delinquent adolescents. Low salaries and poor advancement possibilities in such work may be partly to blame, but so is a human tendency to prefer regularity, security, and comfort, which results in a sloughing off of the less desirable and less conforming (to treatment requirements) patient.

It is strange how often the same delinquent is regarded differently in different settings. Martin, who had been referred to an authoritative agency as a "psychopathic personality" requiring institutionalization, is a case in point. Further psychological and psychiatric examination indicated that the boy was reacting violently to a very difficult home situation and did not have anything like the degree of pathology indicated in the referring agency's diagnosis. He improved markedly in 3 months of intensive treatment in another agency. In the past 5 years he has committed no further delinquencies and is now a respected, self-supporting member of society.

In commenting upon the recruitment of staff to work with such delinquents and their families, Overton has said, "Often the workers with greater experience, whom it was most important to attract, saw this assignment as beneath their professional dignity. It was disappointing that they ran away. . . ."[6]

Experienced therapists seem to be ceding this area to the newcomers to treatment and consequently the less competent.

Clarifying Responsibility

Because of the antisocial nature of the delinquent's behavior outside of the treatment setting, the therapist must at times face up to his own responsibility in regard to the possible consequences of such actions. What turns the balance to allow, or require, the therapist to call in other authorities—the probation officer, the parole office, or the police? What about the therapist's dilemma in handling aggressive behavior which occurs in his presence?

Suppose a delinquent in treatment steals the therapist's fountain pen, or a towering 6-foot teenager loudly threatens a much frailer therapist with physical abuse? Does the therapist have to take it? And if he does not, can the line of demarcation between punishing and setting limits be clearly distinguished?

These questions are not easy to answer. A great deal depends upon the role which the agency sees itself performing in the community. Certainly, however, a concern for other important matters such as an agency's public esteem can add heavy burdens to the therapist trying to treat the delinquent creatively.

Nevertheless, in the actual treatment relationship, the therapist must be in a position to perceive whether his own response is based upon his misinterpretation of the situation because of his own anxieties or whether the situation presents a real danger. If the latter, then active intervention by the therapist, with the help of others, if needed, would seem necessary in instances in which the client himself, the therapist, the agency, or the community might be hurt. Failure to intervene may sometimes constitute an abdication of responsibility and lead to an inevitable failure in treatment.

When, as sometimes happens, the therapist receives a phone call that his delinquent client is getting drunk or threatening to get even with someone, the therapist ought to be able to move out toward the client at a moment's notice. In many cases treatment of the delinquent has to take place not only anywhere but also anytime. Therefore, agency treatment programing should be planned to assure continuous availability. Acting out, precipitated by the frequent crises in the delinquent's life, does not respect time schedules.

The question of what constitutes professional and citizen responsibility calls for much clarification—a task requiring considerable willingness, creativity, and mutuality on the part of all parties involved in the treatment of delinquents. Therapists must think this through not only individually and in their professional groups and agencies, but also with representatives of the bench, bar, law enforcement agencies, and the community at large.

The professional's conscience has probably had to wrestle more with descrying and allocating his responsibilities than with any other single problem. Yet any solution is apt to leave him feeling uneasy. To whom is a professional treatment person loyal and responsible? To his profession? His agency? The community? The client? Himself? He must, of course, be loyal and responsible to all, but the distribution and proportions of priorities need a basic spelling out.

How to do this is not easy to say. Clearly, however, each individual practitioner cannot avoid responsibility for his own actions. The sight of two or more experts testifying in contradiction to one another on the mental status of an offender can reflect not only on the validity of the data presented but also on the dignity of the adversaries and their professions. Such a situation, and others equally unfortunate, arise partly from disparities in role perception within the profession. More research on the role perception of therapists is needed. With more facts professional schools, community councils, and interdisciplinary organizations could join in developing sound guides for individual practitioners and agencies.

Similarly, agency responsibility requires clarification. An "agonizing reappraisal" of agency policies is called for to allow for more fluidities in treatment practice. The increasing effort in many places to "reach out" to the client is a move in the right direction. This sometimes requires teamwork, for one worker alone cannot always be effective in an acute crisis.

Agency Practices

An example of the effectiveness of quick "team action" in a social agency is afforded in the case of 13-year-old Ellen, who ran away from home. If the agency supervisor had not talked to her father, the psychologist to her girl friend, and another agency worker to a relative—all at the same time—it might not have been possible for Ellen to go back home the next day as she did. The case of 14-year-old Joan affords another example. Joan's splenetic father would have needlessly taken her into court on a charge of ungovernability, if several agency workers had not teamed up to speak to father, daughter, and stepmother, and if one worker had not accompanied them home. Dealing instantly with these crises prevented them from further aggravating difficult family relationships.

Since the delinquent is almost always an "unwilling" client, it seems hard to justify, on a basis other than the agency's and the worker's convenience, a rigid insistence upon client voluntariness, office interviews exclusively and only in the daytime, tight time limits for appointments, and noninvolvement with the client's day to day affairs. These practices fit nicely into the middle-class pattern of living. The delinquent does not have such a pattern and if expected to follow one may rebel against the agency.

Many treatment agencies will not accept delinquents for treatment. Some even drop hitherto nondelinquent clients from their caseloads if they become delinquent while under treatment, although this is not now so common as in the past. Referring primarily to delinquents, Bloch and Flynn conclude that: "It is necessary to face the fact that the great majority of voluntary agencies dealing with family and children's problems have intake policies which turn away many of these children. . . ."[7] Public agencies cannot exercise such discretion.

Voluntary agencies, of course, have the right to define their function. Still the policies of many treatment agencies indicate why they are not more effective in meeting the area of social need exposed in delinquency. Their view of a client's repeated failure to appear for appointments as proof of therapeutic inaccessibility is not convincing in the face of the experience of other agencies in working with "hard-to-reach" families.[8]

Clearly many value decisions affecting the treatment relationship lie beyond the therapist. As already mentioned, the agency might impose limitations upon the therapist, reflecting limitations imposed by the community. If the therapist's and agency's responsibility for safeguarding the community is accepted as a basic premise, some questions, with a reverse emphasis, might also properly be asked: How much will the community have to allow for in treatment? What tolerances should it provide? The answers can surely be defined more clearly, specifically, and scientifically.

Such specification requires considerable discussion of agency policy and practice on the basis of staff experience. It also requires carefully designed research. This might include: investigations of the types of antisocial reactions arising during the treatment process, correlating treatment dynamics with behavioral sequences; controlled assessment of the amount of damage to other persons and property wrought by delinquents who are undergoing treatment in comparison with their productivity and positive contributions to others; efforts to determine the effectiveness of different treatment approaches with different types of delinquents. We might then proceed to determine the implications of our findings for legislation, court procedures, police handling, and professional and citizen responsibility.

Value Similarities

While the stress in this paper has been upon the effects of value conflict in treatment, it is equally important to understand the similarities of values between the delinquent and therapist.

The sociologist Kobrin has indicated that delinquents generally are affected by "a duality of conduct norms rather than by the dominance of either a conventional or a criminal culture,"[9] and maintains that no segment of our subculture places a positive value on delinquency per se. Cohen,[10] on the other hand, holds that the delinquent's subculture is essentially in opposition to the values of the dominant middle class.

The therapist does not need to resolve these differences in theory in order to recognize points not only where his delinquent client's values differ from those of the dominant culture, but also where they are the same, as in loyalty to one's family and friends, the need to work for a living, and the right to fulfill oneself. Such similarities in values afford tremendous support for the furtherance of treatment objectives since, in a sense, they provide a common operating base between therapist and client.

Unfortunately delinquents often share some or many of the values of the therapist, yet act in ways which are in contradiction to them. Their value systems, including those values which are directly opposed to the community's, seem to be poorly integrated and unstable, and hence they are confused and conflicted about how to behave.

One of the objectives of the therapist is to help the delinquent hang on to, and indeed augment, those aspects of social conformity and self-control which can be used in keeping him from getting into trouble. I believe that this can be accomplished while helping the individual to fulfill his rights to self-expression and self-realization within the framework of a democratic conception of living.[11]

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INTERPROFESSIONAL TEAMWORK TO SAFEGUARD ADOPTIONS

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THE FACT that the medical, legal, and social-work professions all have functions in the adoption process is gaining recognition.[1] However, a clearer understanding of the specific roles of each and how they mesh together is necessary on the part of the professions themselves as well as the public at large to achieve the kind of coordinated effort that can give the best protection to children against unwise adoptive placement. While in each of these professions many members accept a responsibility in the adoption process, there are in each some members who in their concern tend to lose perspective about their own professional competence and try to play all three roles. Aware of this and other problems, the Children's Bureau in 1955 sponsored a meeting of all the professions concerned with adoption, including medical, legal, social work, nursing, and the clergy, to discuss ways of promoting safeguards.

The Bureau has followed this up in the past two years with a series of meetings held separately with physicians, social workers, and lawyers in an effort to arrive at clear definitions of the role of each in adoption.[2]

The social workers' meeting included social workers from public and private children's agencies, maternity homes, councils of social agencies, and hospital social-service departments. The physicians' meeting included general practitioners, obstetricians, pediatricians, internists, psychiatrists, public-health administrators, and hospital administrators. The attorneys' meeting included attorneys engaged in private practice, law-school professors, and consultants to public and voluntary social agencies. Out of these meetings and similar meetings sponsored by professional organizations, some general principles have evolved. They emphasize each profession's responsibility for performing those special functions which demand its particular skills.

To Each His Role

The following points were made at these meetings:

The Physician. The medical needs of the unmarried mother include confirmation of pregnancy, prepartal care, confinement, and postpartal care. Because of the general confidence in physicians, the doctor is likely to be the first person to learn about her suspicion of pregnancy, sometimes only after she has long denied her fears. A good doctor-patient relationship takes on special importance when the patient is a troubled, fearful, unmarried pregnant woman or adolescent girl who does not know where to turn or how she will manage her future life or that of her baby. Because the effectiveness of medical care for troubled patients depends on meeting many other than medical needs, the physician should refer unmarried mothers to a social agency for help in planning.

Delivery, examination, and treatment of the child are of course physicians' functions. Only a doctor can evaluate and provide treatment, if needed, for the child's physical condition. The physician's special medical knowledge and skill are also needed in judging the development of the child.

A physician's services are also needed for assessing the health and general physical ability of adoptive applicants to accept and care for a child, for studying their physical condition in connection with the cause of their childlessness, and for making recommendations in regard to treatment for infertility.

The Attorney. The attorney is needed for performing all legal services in adoption in respect to or on behalf of the natural parents, the child, or the adoptive applicants. The unmarried mother, the married woman whose husband is not the father of her child, the married couple who cannot adequately assume responsibility for a child, all need to know their rights and legal responsibilities when they are considering giving up their child for adoption. They should also know about the rights and legal status of the child, the specific information carried on a birth certificate, what is involved in paternity proceedings, laws regarding legitimation, and the legal responsibilities of the child's father. The natural parents also need information of a legal nature regarding legal surrender of a child, procedures for judicial termination of the legal parental relationship, and the effect of such a severance of rights on any future plan for the child.

Before a child is placed for adoption an attorney is needed to ascertain the legal status of his parents so that, if the mother is married or divorced, her husband's rights can be fully considered and his consent secured as legally required. An attorney's services are also needed to protect the rights of the child to inherit and to resolve any legal impediments that could place his inheritance rights in jeopardy at the time of adoption or in the future.

The attorney is needed to prepare legal documents required in handling the adoptive couple's petition to adopt the child, and to inform the couple of their legal rights and responsibilities in connection with the adoption. The skill of the attorney is also necessary in handling the legal steps in the adoption process in a way that will protect the decree from later attack insofar as possible.

The attorney's client may be the natural parent or the prospective adoptive couple. In either instance he should refer the client to a social agency for appropriate services.

The Social Worker. The social worker in the adoption process works through an organized social agency authorized by the State to make adoption placements or provide services to unmarried mothers. A person trained in this profession is needed for helping an unmarried mother to deal with her emotional turmoil and arrive at an unequivocal decision as to whether to keep or release her baby, for determining the suitability of the adoptive applicants to care for a child, for selecting the home which seems best suited for the particular child, and for making the actual adoptive placement.

The social worker's skills are important in helping an unmarried mother to build or restore self-esteem, to use her potentials, and to achieve a greater understanding of herself; and, in order to give the child the best opportunity for healthy development, in helping the mother make her decision regarding herself and her child as early as possible.

The social worker's knowledge of the psychological needs of all children and her skill in determining the needs of the particular child are necessary in deciding on the kind of home in which the child will flourish. Social-work training in assessing the personal qualities of people and weighing their flexibility, stability, and capacity to love and care for children is also necessary in the consideration of the suitability of a prospective adoptive home for any child and for a specific child.

The agencies providing this social casework service must develop or call upon resources for medical care, psychiatric consultation or treatment, financial aid, shelter for unmarried mothers, temporary and potential adoptive homes for children, and legal services in helping the natural parents, the child, and adoptive parents.

Coordination of Skills

As important as the medical, legal, and social-work professions are in the adoption process individually, they are greatly handicapped unless they are understood and accepted by each other and unless their work is coordinated.

The physician may be confronted by an unmarried pregnant girl who cannot resolve her quandary about where to live, or whether to tell her parents, or who may be in a state of dangerous despair. The social agency may accept responsibility for a child whose parents have deserted, and whose physical growth has been impeded by neglect. An attorney may be asked for legal counsel and advice concerning the responsibilities involved in adoption by a couple who are in disagreement about a desire to adopt a child.

Each profession provides its special skill to each of these individuals, and yet unless the skills of the other professions are called upon the needs will not be met.

Because the social agency must have all these skills readily available, either on its own staff or within the community, social agencies are in a key position to bring about greater understanding among individual members of each profession of the contributions each has to make to the adoption process. If this understanding is to be widespread among the professions, however, representatives of the local medical and bar associations and of social agencies need to come together for discussion. In a number of communities representatives of the local social planning council have taken the initiative in achieving this.

A hospital administrator is also in a key position to effect understanding among the doctors, nurses, and social workers of the protections and services needed by the unmarried mother and her child. In some hospitals procedures have been worked out to provide such protections.[3] They include provision for referrals to the social-service department or agencies in the community, legal consultation regarding placement and licensing laws and requirements for temporary and adoptive homes, and designation of placement responsibility to the social-work profession. Such development of clear-cut policies and procedures allows each staff member to concentrate on his own responsibility in caring for the patient and her child.

An encouraging sign for improved understanding is the increasing number of statewide gatherings of the professions to discuss the adoption process. A conference of this kind, the Rocky Mountain Regional Conference on Adoptions held in Estes Park, Colo., a few years ago, was sponsored jointly by the Colorado Medical School, Colorado State Department of Public Health, Colorado State Department of Public Welfare, and the Children's Bureau and was attended by physicians, attorneys, judges, nurses, psychologists, clergymen, and social workers from nine States.[4] A physican was chairman both of the planning committee and conference. Many of the participants subsequently became active in efforts to increase understanding in their communities of what is involved in the adoption process. They reported on the meeting of the local or State professional organizations, wrote articles for professional publications, and stimulated interprofessional meetings.

A similar conference on a statewide basis, held in Iowa City, Iowa, in May 1958, was sponsored by the State University of Iowa, including the College of Medicine, College of Law, School of Social Work, Child Welfare Research Station, and Graduate Program in Hospital Administration, in cooperation with the maternal and child health division of the State Department of Health, the division of child welfare of the State Department of Social Welfare, and the Iowa Association of Child Placing Agencies and Institutions.

Last year the 28th Ross Pediatric Research Conference brought nationally prominent doctors, social workers, and lawyers together at Tulane University for 3 days to discuss "The Child and the Law," focusing a large portion of their attention on the legal aspects of adoption.

The Massachusetts Academy of Pediatrics at its recent annual meeting held a session with the subcommittee on interprofessional relationships of the United Community Services committee on unmarried mothers. A pediatrician, an attorney, and a social worker participated in the panel describing the role of each profession in adoption.

As a result of similar joint discussions among professional groups, State medical societies in North Carolina, Ohio, and Utah have approved resolutions that in essence discourage participation of their members in direct placement of children for adoption and recommend use of authorized social agencies for this purpose. The Cleveland Medical Society and the Cleveland Bar Association have approved similar resolutions.

Results of Teamwork

Cooperation among the professions is especially important in order to achieve improved legislation. Legislators and the public must know about the safeguards the laws should provide. Professional teamwork in interpretation is a prerequisite to effective legislative action.

Determination of what services are needed and what gaps exist in a community are special responsibilities of board and staff of social agencies, councils of social agencies, and State departments of public welfare. However, responsibility for taking steps to meet the gaps in adoption services falls on all the professions concerned and is best assumed by joint action. If there are insufficient medical services for unmarried mothers in a State or community, for example, medical and social-work groups can plan together to increase them. Such teamwork has proved to be effective in Connecticut, where the State Department of Health works with social agencies in developing a plan for providing services of all kinds to unmarried mothers.[5]

In Wisconsin and in North Carolina teamwork among the professions has been followed by a decrease in unprotected placements for adoption. In Illinois, social workers, judges, and attorneys, aware that the State adoption and placement laws do not give full protection to children or their parents, are working with a committee from the State bar association to draft bills for introduction into the legislature.

The Greater Hartford Community Council in Connecticut established an interdisciplinary adoption committee in 1955 to bring about better understanding among doctors, lawyers, clergymen, and social workers. In 1957 the committee recommended that placement of children with nonrelatives for adoption be limited to authorized child-placing agencies, and urged that the law be changed to require a social study to be made. The report was accepted by a majority vote. In July 1958 a new law became effective requiring that, except for adoptions by relatives, an adoption petition may not be filed unless the child was placed with the petitioners by a licensed agency.

Increasing Knowledge

Granted that graduate professional schools of all types are faced with a serious problem in selecting curriculum content from the vast amount of knowledge in their own fields, still it seems necessary for medical, law, and social-work schools to impart information on adoption so that their graduates will go into practice aware of the necessity of working cooperatively with other professions.

Medical schools are stressing the need to see a child both as a person and as a member of a family. As part of this approach, some medical schools call on social workers to give their students information about social needs and services including the special problems that a physician sometimes faces in practice in regard to adoption. Such efforts might well include content regarding the social and emotional problems of unmarried mothers and their children, resources offered to them by communities, laws of the State pertaining to placement of children for adoption, and other information physician needs to keep in mind when confronted with an unmarried mother or a family seeking a child to adopt.

The application of various kinds of new knowledge about children's needs can help to improve adoption practice. For example, the studies of the psychiatrist John Bowlby and others on the ill effects of separation of a young child from his mother-figure have deeply impressed adoption agencies with the importance to the child of early adoption. The legal profession, through an analysis of laws related to adoption, has found ways in which legislation can offer greater safeguards to natural parents. Dissemination of information about new discoveries that can affect adoption and about problems that need to be solved is a responsibility of all professions.

There is a beginning interest in learning through research how effective various kinds of adoptive placements have been. For example, in Florida a study is under way of children who were placed for adoption independently approximately ten years ago [see CHILDREN, May–June 1956, page 115], and in Chicago the Elizabeth McCormick Memorial Fund has been considering the question of how to make more significant studies of adoption outcomes [See CHILDREN, January–February 1959, page 35].

In working together to improve adoption practices the professions are coming to realize that their combined knowledge does not yet include all that needs to be known to protect fully the children and adults involved in the adoption process, and that each has a responsibility for seeking on its own and with other professions the missing links in such knowledge.

Effective cooperative effort in the adoption process requires conviction as to the importance of providing protections to parents who might be considering giving up a child for adoption, to the child whose opportunities in life are determined by his adoptive placement, and to the couple that wants a child and can offer him love and security.

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An essay-review . . .

ARE PARENTS CHANGING?

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THE STUDY of child-rearing practices has been intensified by psychologists, anthropologists, and sociologists in the past decade. This demonstrates a growing awareness of need for more empirical data about the development of children. We assume, and apparently correctly, that knowledge of the child's experiences during the course of his development is important for the understanding of adult behavior, and so also for increasing our knowledge of the prerequisites of mental health. Moreover, examination of child-rearing practices is important as a basis for comprehending cultural continuity and change, for culture is transmitted through child-rearing practices that aim to develop personalities compatible with cultural requirements.

Many observers of the social scene have commented on the social and psychological effects of changes occurring in our society: the movement toward conformity and materialism; the emotional quietism in educational circles; the decentralization of large urban areas; the mounting levels of production and consumption; and the increasing speed and uncertainties of the space age. There is need, however, to get beneath the surface and begin empirical validation of these assumed changes and to assess the intensity of their impact, particularly since they can affect our national life and even survival. Of course, the segments of a society as complex and diverse as ours change in varying degrees and in varying ways. The problem for the social scientist is to develop concepts and methods by which the broader changes can be examined in relation to their impact on children. One aspect of this larger problem is the relationship between one's occupational situation and his value system as reflected in his child-rearing practices.

Daniel R. Miller and Guy E. Swanson in their recent book "The Changing American Parent"[1] add new dimensions for the study of child-rearing practices by presenting the concepts of "individuated entrepreneurial" and "welfare bureaucratic" personalities—both of which reflect the individual's type of occupational setting. Heretofore, nonsociologists have tended to adopt many sociological concepts, including social class and social structure, often without closely examining their psychological significance. In this book, however, a psychologist (Miller) and a sociologist (Swanson) have integrated their combined knowledge and points of view toward a common problem: the study of child-rearing practices in a large urban community. The book is significant as an attempt to investigate the role of the economic social structure in child rearing.

Occupational Settings

The authors apply the terms "individuated entrepreneurial" and "welfare bureaucratic" to situations in which individuals perform their tasks—their places of occupation. These they call the "integration setting" since they denote the way an individual becomes integrated with others.

The "entrepreneurial" refers to integration settings having the following features: They are small in size, have high division of labor, possess relatively small capital, and provide mobility and income through risk taking. Such integration settings, according to the authors, tend to isolate people from one another and from the controlling influence of the broader cultural norms. They hypothesize that in families where the primary occupational setting is entrepreneurial the parents will encourage their children to be highly rational, to exercise great self-control, to be self-reliant, and to manipulate their environment.

The term "welfare bureaucratic," on the other hand, refers to large organizations which employ many different kinds of specialists, have substantial capital, and pay salaries or wages. Upward mobility in the "welfare bureaucratic" setting occurs through specialized training for particular positions rather than through success in taking risks. This type of setting offers the individual considerable support in meeting personal crises, as well as considerable security in regard to continuity of employment and income. The authors hypothesize that the children of persons employed in such settings will be encouraged to be accommodative, to allow their impulses some spontaneous expression, and to seek direction from organizations in which they participate.

Whether or not the authors have oversimplified these settings or whether such clear distinctions exist are open questions. The interesting point is that the authors have tackled a traditional anthropological problem, to test whether the value system held by the parents—which, they hypothesize, is reflected by the father's occupational setting—leads to, or is related to, specific child-rearing practices. Thus, a kind of culture continuity is envisaged, the children being reared to adapt to the kinds of settings their parents value.

The validity of such hypothesizing has yet to be fully demonstrated, for the study's findings are not striking. Part of the failure to obtain the kinds of findings expected may arise from the limited length of the interviews and of the limited scope of the study; for the authors have tended to focus on mothers, who, in the families studied, are not direct participants in either type of occupational setting. Studies of this nature, bringing in both parents, are needed.

The intent of this discussion, however, is not to focus on the methodological limitations, of which the authors themselves are aware, or on their methodological sophistication which becomes self-evident in many sections of the volume. It is to note the contribution of their orientation to study of the broad social scene and examine some of the implications.

As the authors in this volume tend to suggest, a "welfare bureaucratic" occupational setting, where certain kinds of individualism are not encouraged, frustrates some persons to the point of unhappiness. On the other hand, it makes others feel relatively comfortable and secure. The big question that arises in connection with the effects of this type of setting on the person's child-rearing practices is whether or not he is attracted to it because of the kind of goals, values, and attitudes he has, or merely because of the limited choices available or the attractiveness of the salary. A person is faced with potential conflict if he does not really want to work in this type of setting and is seduced into it by its security-giving features. In pointing up these kinds of questions, the authors pose important problems for further research. The fact that some of the study's findings reflect differences between the entrepreneurial and bureaucratic groups suggests the value of delving further into these relationships.

The Study

The authors interviewed 582 mothers in the Greater Detroit area. They classified them into entrepreneurial and bureaucratic groups, with further breakdowns within each group into upper-middle and lower-middle class.

They have found some significant differences between the entrepreneurial and the bureaucratic mothers: for example, among the lower-middle-class groups, entrepreneurial mothers are more likely than bureaucratic mothers to begin urinary training before the baby is 11 months old. Similarly, a difference exists between the two lower-middle-class groups in the use of symbolic punishments—blame to induce feelings of guilt rather than direct action such as spanking. These practices are tests of the author's hypotheses: that early training is related to such characteristics as self-reliance and independence, and, consequently, that those individuals who are so oriented act accordingly, but the differences between entrepreneurial and bureaucratic groups do not appear in the upper-middle-class families. The data tend to support the theory that entrepreneurial mothers tend to place more emphasis on an active manipulative approach toward life than bureaucratic ones.

The authors report little success in forecasting differences between the upper and lower classes *within* the entrepreneurial group. However, when they compare the entrepreneurial and bureaucratic groups and control for religion—Protestant and Roman Catholic—a number of their findings are in the anticipated direction, especially when they compare the two religious groups of one entrepreneurial group, holding social class constant. An illustration of the findings is that Protestants are more likely than Catholics to use symbolic rewards and punishments. The same results are not found with the bureaucratic group.

Bringing in religion as a variable is in itself a considerable contribution to the study of child-rearing practices. However, this reviewer was surprised to note that Protestants are lumped into a single group, since they vary so in religious ideology. Control for ethnicity is suggested, but not sufficient for the purpose.

Thus, in attempting to analyze together the effects of religion, integration setting, and social class, the authors move away from the simplicity of the criteria generally used in child-development research toward a consideration of the large variety of criteria that should be recognized and controlled. They are completely aware of the complexity of what they are studying.

Near the end of the book they speculate about the relation of family personality to bureaucracy; the effects of increasing urbanization on the family; the questions of companionship in the entrepreneurial and bureaucratic families; and what persons in these groups tend to expect of each other and of themselves in a society where occupation and income are measurements of status.

Although the authors say their concern is with the *changing* American parent, many questions as to how and to what degree parents have changed are left unanswered. This is at least partly due to the fact that little research of this nature has been done in the past. However, the authors do note some changes reflecting societal changes in requirements and expectations, and present an interesting historical analysis of shifts in child-rearing orientation and philosophy.

Research Stimulus

This book, then, offers a variety of suggestions for future research. The limitations in the extent and depth of the undertaking should not detract from its value as a stimulus to future research and conceptualization.

One can argue that the assumption that the occupational setting is of such paramount value in relation to child rearing is highly inferential. There is also the question: Does the mother necessarily reflect the values held by her husband? Some studies have indicated that there is no correlation between mothers' and fathers' child-rearing practices. The authors themselves give a schema suggesting further areas of detailed thinking in regard to the relationship between a person's occupational setting and value system.

One could go on endlessly posing questions for further research as a result of reading this book. However, the questions already raised indicate that some caution should be employed in moving "whole hog" in the direction the authors suggest. Nevertheless, exploratory work of this kind offers new vistas for more inclusive types of conceptual schemes for research workers, helping us to move away from the social class studies of the past. A need for this has been made apparent by Littman and his associates [2] who have reported that a comparison of three studies of child-rearing differences in as many communities pointed "quite clearly to the absence of any general or profound differences in socialization practices as a function of social class."

However, it is also important to keep in mind that studies done, as was that of Miller and Swanson, on the basis of survey techniques—in which the children themselves are not observed or studied—raise considerable questions as to the significance of the results. It is easy to lose sight of the fact that the basic purpose of studying child-rearing practices is to answer the question: What differences, if any, do specific practices make in the child's current and long-term behavior?

Studying the parents as such is of interest and may contribute to an understanding of our broader society; but the "proof of the pudding" lies in determining whether or not these differences are of real import. Thus, the next step is to study children in relation to the differences observed among their parents. In other words, we still must validate the basic hypothesis that differences in child-rearing practices among any kinds of groups result in differences in their offspring.

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A NEW LOOK AT HOMEMAKER SERVICES

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SOCIAL AND HEALTH AGENCIES, like business organizations, need to take inventory periodically—to take stock of what they now have as a step in planning for the present and the future. Such an evaluation may confirm belief in the accustomed way of doing things or it may bring a new look leading to developments in an entirely different direction or to a realignment of priorities.

Such a new look was one goal of a group of approximately 300 people who met in Chicago recently. They were there attending the National Conference on Homemaker Services, whose purpose was to stimulate the development of homemaker services throughout the United States. The 2-day meeting was sponsored by 26 national voluntary welfare and health agencies and 8 units of the Department of Health, Education, and Welfare. The conferees represented many organizations—National, State, and local; public and voluntary; welfare and health. They included doctors, nurses, social workers, therapists, home economists; leaders from industry, labor, health insurance groups, and communities.

The participants made several outstanding suggestions on which there seemed to be general agreement. They expressed the belief that in community planning priority should be given to services which help people to remain in their own homes, providing it is suitable for them to do so—families with children, the chronically ill, and the aged.

They expressed repeatedly another concept: that homemaker services should be available to all people in the community who need them, regardless of income or geographic location—payment to be made in accordance with financial status. If this concept is carried out, provisions for homemaker service must be greatly expanded. Therefore, the conferees suggested that National, State, and local agencies must work together and that there must be teamwork between the health and welfare fields.

Closely allied to this idea of community-wide availability was the conviction expressed that voluntary agencies alone could not provide sufficient homemaker services to meet the increasing demands arising out of conditions due to death, illness, incapacity, infirmity of age, or other social, economic, and emotional difficulties. Therefore, the conferees suggested that governmental agencies at all levels should make provision for homemaker services, directly or by payment to other agencies, for those unable to purchase services for themselves. Public agencies, it was maintained, should provide a broad service to meet all types of problems and should be able to serve all income groups when such service does not duplicate an existing service.

Structure

Only three written papers were presented at the conference. One by Katherine B. Oettinger, Chief of the Children's Bureau, on the needs of individuals and families for homemaker services, spelled out the reasons for the conference. One by Dr. David E. Price, Assistant Surgeon General of the Public Health Service, described the "inextricable partnership of health change and social change." And in another, Sol Morton Isaac, president of the Ohio Citizens Council for Health and Welfare and past president of the Family Service Association of America, discussed community responsibility for facing the demand for services to help people live at home.

The greater part of the time was given to 19 discussion groups planned for approximately 20 people each. Previous to the meetings each participant had received five pamphlets prepared by the Department of Health, Education, and Welfare. These included 12 descriptive statements of agency programs;[1] preconference study group reports;[2] a report of a nationwide study of homemaker services;[3] a directory of such services;[4] and a descriptive leaflet for popular consumption.[5]

Each group decided how the allotted time would be used and at the end recorders turned in their reports.

A report of the 1959 National Conference on Homemaker Services, Chicago.

One occurrence at the National Conference on Homemaker Services not alluded to by the author in the accompanying article was the presentation to her of a plaque in recognition of her own part in the stimulation and development of homemaker services. In making the presentation on behalf of the Conference, Mrs. Katherine B. Oettinger, Chief of the Children's Bureau, referred to the meeting as "a pinnacle in her steady effort for homemaker service" and told of Miss Morlock's work in organizing the first conference on "visiting housekeeping services" called by the Bureau in 1937, in helping to found the National Committee on Homemaker Service, and in "journeying over the land" for nearly a quarter of a century "urging, encouraging, prodding, seeking to improve" homemaker services.

Miss Morlock, who retired from the Bureau's staff on March 10, was similarly honored in New York in January for her work in behalf of unmarried mothers, at a dinner given her by the National Association on Services to Unmarried Parents, an organization she also helped to found.

These were later summarized to the entire conference by the five section chairmen. Although a particular discussion group might voice agreement on a certain point or even be sufficiently formal to register a vote on a recommendation, no action was taken by the conference as a whole. Because this method was followed, this article can only present some highlights of what transpired.

Recurring Ideas

A reading of the recorders' reports and the speeches reveals many recurring ideas. Some of these are:

More homemaker service for the aged. In urging increasing service to the aged, the groups suggested that when a community starts homemaker service it should include plans for the elderly as well as for families with children. They also emphasized the importance of a close relationship between social and health services because of the frequency of physical and mental impairment among the elderly.

It was repeatedly pointed out that many older people who might otherwise not be able to remain in their own homes can do so if they have the regular help of a homemaker for only a few hours a week; that for them this means a happier, more independent life, and that for the community it is often less costly than caring for the person full-time in an institution.

Determining length of service by need. As was to be expected from this multidisciplinary group, with many of the leaders in the health field joining forces for the first time with social workers, the health aspects of conditions creating the need for homemaker services received considerable emphasis. Dr. Price pointed out that the Public Health Service's survey of homemaker services [3] revealed that 93 percent of the homemaker service given was in situations where there were health problems, in many instances chronic illness requiring long-time homemaker service. The conclusion follows, as one group noted, that the length and amount of time homemaker service is given to people should be determined by their needs, periodically reevaluated.

The training of homemakers. This conference gave particular attention to the importance of training homemakers, the content of training, and how to accomplish it. The conferees pointed to the need to define first what the job is in order to know what homemakers should be trained to do, and then to gear the training to the homemakers' level of understanding.

Interpretation. There was general agreement on the importance of interpretation, both of existing services and of the need to provide further services. Those mentioned as especially needing to know about homemaker service were doctors, nurses, and hospital personnel; representatives of labor and industry; ministers, teachers, service organizations, and community health and welfare agencies.

It was suggested that various media be used with imagination to put the story across, and that this task should not prove too difficult since homemaker service is visible, tangible, and a concept easy to grasp.

Interest in developing homemaker services, it was suggested, may be created by one or two people, or by a group of people. Frequently they will need immediate consultation in planning, perhaps from the community health and welfare council or the State department of welfare or health or a local agency. A group representing various interests in such a service can be helpful in assessing need and setting up steps for developing and nurturing a program.

New Emphases

Other concepts emphasized had a touch of newness or strength not apparent at earlier conferences. There was an emphasis on flexibility of program; on the importance of keeping the focus on the needs of people; on using the service imaginatively; and on the multiplicity of ways in which a good homemaker service can strengthen the community.

Pleas were made for extending homemaker services not only geographically, but also quantitatively and qualitatively and for making them available more quickly in a time of need.

Prevention. Although homemaker service has frequently been referred to as a preventive service, there seemed to be more conviction about this than in the past. The participants asked for a broader coverage to prevent breakup and deterioration of the family. They wanted this service not simply for the underprivileged, lower income group with multiple problems, but for the so-called normal family who might never have been known to a community agency had not adversity hit. It was pointed out that among other advantages an agency homemaker service offers certain protections such as an ability to adjust to the individual's or family's needs; to guarantee quality, reliability, and continuity of service; objectivity, knowledge, and skill in evaluating the need for the service and in providing it; supportive help and sharing of responsibility both to the homemaker and family; removal of direct financial relationship between the family and homemaker; helping the family to develop and use its own resources.

The participants also expressed conviction in another function of homemaker service closely allied to its preventive role—that it has much to offer to parents who need and want help in providing better care to their children and their home. These are often young parents whose intentions are good but whose own background is such that they have not known the better things of life, and hence their care of their children and their homes is so substandard that the community becomes disturbed about it. Help from a motherly, well-qualified homemaker, working with a caseworker, can change the pattern of life both for those immediately involved and for future generations. And it can save the community much in time, energy, and dollars and cents.

Industry and labor. A new note was also struck in the emphasis on the importance of homemaker service to industry and labor. Such a service, it was pointed out, conserves manpower and cuts down insurance and production costs by alleviating anxiety of the workers, enabling dependents to secure medical care, and helping to maintain family units during periods of threatened disruption.

The group discussing this subject recommended that the need for homemaker service for industrial personnel be assessed so that management and labor may recognize the desirability of supporting such a service. It also suggested that this type of service be considered as part of industrial medical care plans, urging vigorous interpretation of this approach.

Another new proposal was that voluntary health insurance should include coverage of the cost of homemaker service as a part of medical care. This would require the identifying of the insurable service, its incidence, duration, and cost.

Controversial Issues

Other questions were thrashed out but not resolved.

Auspices. One of these relates to the auspices under which homemaker service can be administered. The participants seemed generally to accept the concept of homemaker services as a community service, an integral part of the health and welfare program, financed by voluntary or public funds with the family or individual paying in keeping with his ability; but they expressed different viewpoints as to its specific auspices.

One group reported as follows:

"1. The auspices of a homemaker services program may be differential and need not be a social agency.

"2. However, because the professional training of the social worker gives him the broadest base for understanding family life, he is better able to administer a homemaker services program than any other professional person. This is desirable and will provide optimal service, although it may not be realistic to say social work administration is necessary."

Another group expressed the opinion that experience is too limited for categorical statements to be made on the relative values of each type of agency sponsorship, and recommended that "primary emphasis be placed on each community evolving its own approaches."

Still another group reported:

". . . establishment of a homemaker service might be considered as furthering the programs of existing agencies—which would be as broad as those agencies' coverage. If in a particular locality the need manifests itself for the establishment of a new agency providing homemaker service as its sole responsibility, this could be set up as an independent agency accepting direct applications or giving service to public or private agencies not having a homemaker program of their own or one adequate to meet their needs. The solution of the latter problem (insufficient service) might be the responsibility of a community council of welfare and health agencies."

Agreeing that auspices for maintaining services would vary, this group maintained that what was important was "to consider the needs of the people rather than the organization."

Another group recommended research "to determine under what circumstances it is preferable to have a specialized agency providing recruitment and training of homemakers and service to a total community (from which various other agencies may, if they desire, purchase service) and when it is better to have the individual agency within the community assume responsibility for its own recruitment, training, and service." To provide the basis for such research it suggested that an increasing variety of agencies, both public and voluntary, provide homemaker service on an experimental basis.

Still another group commented: "Regardless of whether a homemaker service is based in a social or in a health agency, appropriate health and social services should be available when needed."

Discussing the question of appropriate auspices in his address, Mr. Isaac pointed out that it requires the facing of difficult decisions. If each agency which regards homemaker service as useful to its objectives creates its own service to meet its special requirements, the results in duplication of effort, unnecessary expense, and lack of coordination will be the kind of fragmentation that weakens community support for and understanding of the service, he warned. Asserting that "centralization appears to be considerably more effective" he nevertheless pointed to problems of determining standards, sources of support, and eligibility for service that have to be faced in the establishment of a centralized service and urged the resolution of these issues in each community through its council of social agencies.

Social casework. One of the most controversial issues in regard to homemaker services involves the use of social casework—what it is, who needs it, and whether it is an essential part of a homemaker program. This was reflected in the conference discussions.

On the one hand were those who pointed out that many people who need a homemaker have economic, social, and emotional problems in addition to the health difficulties which precipitate the request for homemaker service, and that the purpose of the service is to maintain and strengthen family ties and relationships and to help the individual to be as self-sustaining as possible. They also pointed out that homemaker services is a community service involving accountability for the spending of voluntary and public funds. Maintaining that casework should be defined broadly as "helping people in trouble" and its use adapted to the particular situation in the family, they argued that the giving of homemaker service involves the casework process in helping the individual determine whether this type of service is the best plan and if so, what will be required of the homemaker, the length of time she will be needed, and the fee to be paid. They also maintained that the selection, training, and supervision of the homemaker involve casework knowledge and skills. If casework isn't a part of the program, they asked, isn't the service something other than homemaker service?

A homemaker with two of the hundreds of children she has cared for in their own homes in time of crisis in the family. She has been a part of the homemaker service of the Catholic Charities in Cincinnati for 16 years.

These have been and are now the concepts accepted by most agencies providing homemaker service up to the present time. Their experience has led them to believe that casework is an essential element in homemaker service, particularly at intake. This point of view is shared by many health agencies.

On the other hand, there were those who raised questions as to the extent to which casework is essential in providing homemaker services to self-sustaining "normal" families and individuals who need and are able to pay for it. There was also discussion of whether or not members of other professions, such as the public health nurse, were equipped by their training to carry some of these responsibilities.

One group suggested that the issue concerning the use of casework in homemaker service might best be clarified by studies of homemaker services under a variety of auspices and using a variety of personnel, such studies to be carried out by a multidisciplinary team. These studies, it was suggested, would also throw light on the standards necessary to make the service effective. The importance of establishing standards of service was emphasized throughout the conference, in formal speeches and discussions.

Terminology. Terminology was another point at issue. When this type of care first started in the 1920's, it was known as "visiting housekeeper service." In 1939 at a conference called by the Children's Bureau representatives of a group of agencies providing the service decided that "supervised homemaker service" was a broader term connoting greater dignity. Several years later, however, the National Committee on Homemaker Service—which was founded at the Children's Bureau meeting—dropped the word "supervised" using simply "homemaker service." For the purpose of the National Conference the term "homemaker *services*" was used to include all types of "home help" service.

Although some dissatisfaction has been expressed with the term "homemaker service," it continues to be generally used throughout the United States and Canada. However, two new titles were suggested at the conference, "family aide" and "home aide," as being more descriptive of the service and perhaps more acceptable to those using it.

Followup

At the close of the conference the question frequently heard was "where do we go from here?" A written report would be published in book form, but this was not enough. How was the stimulus the conference had generated to be put into action?

The conferees agreed that the extension of homemaker services would require a vigorous partnership between public and voluntary organizations in both the health and welfare fields and on National, State, and local levels. Some suggestions were:

1. That the executive committee of the National Conference on Homemaker Services plan a multidiscipline evaluation of the variations in homemaker services existing today.

2. That a continuing national mechanism be established, through the cooperative effort of all levels of voluntary and official agencies, to study such programs and to help communities interested in developing or expanding them.

3. That conference findings be brought to the attention of all State departments of health and welfare, national voluntary health and welfare agencies, and their local affiliates.

4. That the 1960 White House Conference on Children and Youth and the 1961 White House Conference on the Aging include discussions of homemaker services.

5. That the National Committee on Homemaker Service provide national leadership for coordination, stimulation, and research in homemaker service, broadening its membership, if necessary, to include disciplines not now represented.

6. That the Department of Health, Education, and Welfare continue and expand the consultative service it is presently providing the States.

Thus did the conferees accept Mrs. Oettinger's charge, made at the opening session, to keep their eyes on goals in their efforts to chart "the future course of homemaker services in this country."

The day after the conference the National Committee on Homemaker Service held its annual meeting in Chicago, a schedule planned to provide for immediate followup discussion of the conference. This resulted in a resolution that the National Committee and the executive committee of the conference arrange to meet in the near future with representatives of the sponsoring groups to formulate a plan of further action.

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[1] U.S. Department of Health, Education, and Welfare: Homemaker services in the United States, 1958; 12 statements describing different types of homemaker services. Public Health Service Publication No. 645. 1958.

[2] ———: Homemaker services in the United States, 1958; reports of preconference study groups. Public Health Service Publication (mimeographed). 1958.

[3] Stewart, William H.; Pennell, Maryland Y.; Smith, Lucille M.; Homemaker services in the United States, 1958; a nationwide study. U.S. Department of Health, Education, and Welfare. Public Health Service Publication No. 644. 1958.

[4] U.S. Department of Health, Education, and Welfare: Homemaker and related services, 1958; a directory of agencies in the United States. Children's Bureau Publication No. 370. 1958.

[5] ———: Homemaker service. Children's Bureau Folder No. 46. 1958.

HERE AND THERE

Pediatrics and Delinquency

Some ways in which pediatric services can help prevent juvenile delinquency were discussed at an interdisciplinary conference sponsored by the American Academy of Pediatrics and the Community Council of Greater New York at Arden House, Harriman, N.Y., February 16–18. The 40 conferees included pediatricians, child psychiatrists, general practitioners, social workers, sociologists, and educators.

The immediate objective of the meeting was to formulate guidelines for local pediatric committees on delinquency prevention, which have been established in 35 States under the auspices of the American Academy of Pediatrics. The conferees recommended that the guidelines be published in a pamphlet stressing the magnitude of the juvenile-delinquency problem and the complexity and interrelationship of its causal factors.

Noting that the pediatrician who wishes to help combat delinquency can act not only as a physician in his face-to-face work with children and their families but also as a citizen in the broader field of community service, they recommended that the pamphlet also include specific suggestions on what a pediatrician can do as a practitioner and as a citizen to counter community conditions that lead to juvenile delinquency.

Among appropriate functions in delinquency prevention the participants defined for pediatricians were case finding of potential delinquents, counseling of their families, referring them to other agencies for adjunctive services, and strengthening preventive services through study and action with other citizens. They also expressed the opinion that social agencies should draw on the special skill and knowledge of the pediatricians who refer families to them for service.

The conferees also suggested that the scope of pediatric training might be broadened to embrace the family and the community and that the medical-school curriculum might include sociological, social-work, and psychiatric content, not as a separate course, but integrated into the present courses. As one teaching method, they urged the use of interdisciplinary panels in medical teaching, pointing out that such panels, with pediatric leadership, have already been used successfully in several medical schools and communities. The conferees also expressed the conviction that every pediatrician needs to know enough about the emotional problems of children to recognize symptoms of trouble and be able to refer an emotionally disturbed child for specialist care when necessary.

In view of the facts that many juvenile delinquents are members of lower-income families and that pediatricians as a rule work mostly with upper- and middle-class families, the participants explored ways of bringing more pediatric service to the lower-income populations. A promising approach to this, they suggested, is for pediatricians to play a more important role in the health programs of public schools in districts of lower economic levels.

—Lincoln Daniels

UNICEF Action

The Executive Board of the United Nations Children's Fund (UNICEF), meeting in Geneva, March 2–13, adopted a new program of assistance to countries wishing to improve the care of children deprived of their own homes. The program will be based on a report prepared by the United Nations Bureau of Social Affairs in response to a resolution introduced a year ago by the U.S. Delegation to UNICEF.

Because in many countries institutional care is the traditional method of caring for children without families or for whom the natural family is unable to provide, the program's short-range aim is to help countries improve the quality of their institutional care. Its long-range aim is to help countries develop well-organized systems of social services which will help preserve and strengthen family life and foster opportunities for the healthy growth of the personality and abilities of the child. Preventive services such as day care will be especially stressed.

In approving the program the Board made it clear that technical guidance must come from the Bureau of Social Affairs, which should employ a qualified child welfare worker for the purpose.

With a $135,000 financial limitation for the first year, the program will put first emphasis on training of personnel.

Also before the Board at the March meeting was a proposal to extend aid to primary education. While this was not approved in principle, some increased emphasis was authorized for training teachers in the fields of traditional UNICEF interest such as health, nutrition, hygiene, and home economics.

Over $10 million in assistance to 71 specific programs in 50 countries and territories was endorsed. Recipient governments committed themselves to spend over $32 million of their own funds on the programs.

—Katherine Bain

Juvenile Delinquency

Delinquency among the District of Columbia's Negro children dropped sharply in the period 1954–58, while delinquency among white children remained practically stable, according to the District government's Interdepartmental Statistical Committee. In 1954 the delinquency rate for Negro children—the number dealt with by the police or court for delinquent acts per 1,000 Negro children aged 5 through 17—was 37.1; in 1958 it was 21.2. The rate for white children was 15.3 in 1954 and 15.2 in 1958.

During this period the Negro population in the 5 to 17 age group grew from 69,000 to 93,500, but the number of Negro delinquents dropped from 2,562 to 1,980. The white population in the same age group dropped from 62,000 to 52,000, while the number of delinquents fell from 946 to 792.

In commenting on these figures the committee pointed out that developments in the District during this period included: the creation of a youth council, which works mainly through citizens' area boards; the establishment of additional institutional facilities for care of delinquents, enabling the department of public welfare to accept more delinquents from the court and to give them longer and better care; and creation of a youth-aid division in the police department.

The period coincides with the first 4 years of racial integration in the District's schools.

Family Allowances

Government allowances to families with children are payable in 38 countries, and health and maternity insurance programs in 59, according to a survey made by the Social Security Administration's Division of Program Research. Family allowance programs, found mostly in Europe, have spread fairly rapidly, according to the information gathered. In some countries—mainly Scandinavian countries and members of the British Commonwealth—the allowances are paid to all resident families with one or more children. Elsewhere, for the most part, the allowances are payable for families of employed workers only. Most of the health and maternity programs provide both cash benefits and medical care to insured persons in case of sickness or maternity. About one-sixth pay only cash benefits, but in some countries medical services are furnished directly by the government under a separate program applying to all residents rather than to social-insurance contributors alone.

The survey showed that many of the less economically developed countries are starting health and maternity benefit programs gradually. Benefits may first be provided in the capital city, then extended to other localities as new clinics and hospitals are built.

Findings of the survey are included in the report, "Social Security Programs Throughout the World." (Price $1 from the Superintendent of Documents, U.S. Government Printing Office, Washington 25.)

Mental Health

As a step toward helping State health departments to combat hereditary metabolic diseases that cause mental retardation in infants, the Children's Bureau held a meeting of one of its technical committees February 26–27 at Washington to review techniques for finding infants with phenylketonuria, a disease that usually results in brain damage if treatment is not begun early—preferably within the first 3 months of life.

Noting that the proportion of persons with the disease is relatively high among certain groups in comparison to the low incidence in the general population, the committee recommended that priority be given to testing "high risk" groups. To discover high risk families, the committee recommended that tests should be given to all patients in institutions and clinics for the mentally retarded and to persons on their waiting lists, to children in clinics for convulsive disorders, to those with eczema, and to those in special classes for slow learners. Persons in these groups in whom confirmatory tests show phenylketonuria, the committee observed, would probably be too old to benefit from treatment, but their newborn relatives may benefit if blood tests are given them and if treatment is begun at once for those who have the disease. One conferee reported that the disease can be diagnosed by a blood test as early as the 12th hour of life.

Describing their experiences with urine tests in mass screening of infants for phenylketonuria (see CHILDREN, July-August 1958, p. 158), conferees reminded the group that the results of such tests may not be positive before the sixth or seventh week of life, and that the diagnosis should be confirmed by blood tests before treatment.

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At the Harvard School of Public Health, Department of Maternal and Child Health, a study is currently in progress to inquire into the situation of children of families in which a parent has been hospitalized for mental illness. These children are assumed to have the same types of risks as other children whose fathers or mothers have been removed from the home because of death, illness, or other reasons, with the added risk factor of having lived with a parent who was mentally ill.

The study is directed toward the investigation of currently admitted mental hospital patients and their families, to determine: (1) the arrangements made for the care of the children through the family of the hospitalized parent or through the aid of social, health, or welfare resources within the community; (2) what might be done with regularity by the psychiatric hospital and other health and welfare agencies to assure the well-being of the children.

The monthly admission sheets of two Massachusetts State hospitals have been examined for the selection of patients between the ages of 15 and 54 who are married, widowed, divorced, or separated, and have children under 21 years of age currently living at home. A schedule of questions has been devised to elicit from the patients' hospital records indications of the children's situation and of arrangements that have been made for their care during the parents' hospitalization. Six weeks following hospital admission an interview is conducted with the patient's most closely concerned relative or the patient himself if he has already been released from the hospital, or both. A second interview is carried out 6 months after the hospital admission date. Each interview is conducted according to the same schedule of questions, with the emphasis in the 6-month interview on changes that have taken place.

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Recommendations for State action for the mentally retarded have been issued by the Council of State Governments in the report of a conference called last fall by the Council's Interstate Clearing House on Mental Health. Among the 72 conferees were a number of State legislators and specialists in the fields of education, welfare, health, mental health, and employment, from State and National voluntary and public agencies.

Pointing out that the problems of the mentally retarded require concern from several departments of State government they urged, among other steps: that each State establish an interdepartmental group for joint planning of services for the mentally retarded; that major emphasis in institutional placement be put on voluntary rather than judicially determined admissions; that cases in judicial proceedings for commitment be referred to appropriate community resources for medical, psychological, and social diagnosis and evaluation; that State funds be appropriated for research on a continuing basis; that localities be required to provide programs for the educable mentally retarded and be permitted to provide programs for the trainable, the additional costs to be borne by the State; and that State agencies with programs for the mentally retarded carry on inservice training for personnel.

Recreation

As a step toward helping parent groups in middle-income cooperative housing developments to provide high-standard recreation programs for children, the Play Schools Association, New York City, and the city department of health are carrying on the second 2-year phase of a pilot project for helping families to adjust to group living. The project is supported by foundation funds.

In the first 2-year period, completed in 1958, recreation programs were operated and financed by more than 25 volunteer parent groups in 8 housing "cooperatives," with a total of more than 7,500 families. The program, which involved 3,342 children, from 2½ to 16 years of age, included cooperative nursery schools, summer day camps, after-school play groups, preteen clubs, and teenage social and lounge groups. The project consultants helped the parent groups to survey the community to find out about children living there; hold educational meetings and workshops; develop an effective, organized structure for activities; explain standards set by city licensing agencies; supervise the programs; and work toward the development of good relations between the cooperative and other families of the neighborhood.

In the next 2 years the project will establish a central information and education bureau to provide interpretive materials, workshops, and leadership training sessions to help housing cooperatives with community activity programs: test with the prospective tenants of a project under construction whether families can be helped to adjust to their new homes by anticipating problems; explore new techniques for the constructive harnessing of the resources of different ethnic and economic groups within the community.

An 80-page report on the first 2 years' work may be obtained from the Play Schools Association, 41 West 57th Street, New York 19, at 75 cents.

Fluoridation

Although most of the largest cities in the United States now add fluorides to their water supply as a step toward preventing dental caries in children, the rate at which communities are initiating water fluoridation programs has been declining steadily in the past 6 years, according to the Public Health Service. Since 1953, the peak year for the spread of this public health measure, when 243 communities began fluoridation, the number of communities per year initiating such programs has dropped considerably. Only 110 places began fluoridating in 1957 and only 131 in 1958. The Service attributes the slowing down in the rate of community acceptance of fluoridation programs to two circumstances: the organization of opposing forces and the fact that those communities which normally adopt new health measures quickly had already introduced fluoridation by 1952.

More than 41 million people in this country (about one-fourth of those served by community water supplies) are drinking water containing at least the minimum of fluorides recommended for dental caries prevention, according to the Service. Of these, about 7 million live in places where the water is naturally fluoridated.

Most of the 34,600,000 people drinking water to which fluorides have been added live in the larger cities, the Service notes. Sixty-six percent of cities with populations of more than half a million, and 32 percent of those with populations of 10,000 to 500,000 have fluoridation programs. But among places with populations of 2,500 to 10,000 only 17 percent have such programs, and in those with populations of less than 2,500, only 5 percent.

After extensive epidemiological studies and the observation of three controlled experiments, the Public Health Service endorsed the fluoridation of public water supplies in 1951. Thirty-one national and international organizations have followed suit.

Toy Safety

A toy safety committee, established last fall by the Home Conference of the National Safety Council, has offered to serve as a clearinghouse for complaints about unsafe toys. The committee will relay the complaints, along with suggested safety standards for the toys in question, to the Toy Manufacturers Association of America, Inc., which is cooperating with the committee in efforts to reduce the danger potential in toys.

The clearinghouse plan was made at the committee's second meeting, held in New York in mid-March to coincide with the association's annual Toy Fair, thus giving the committee members an opportunity to view the toys which will be on the market for the next Christmas shopping season. Recognizing that with a few notable exceptions, such as lead or lead-painted toys, the danger in toys lies chiefly in their misuse, the committee decided to devote its main efforts to urging professions and organizations having contact with parents to educate them in the principles of toy safety.

Parents, the committee warns, should learn the importance of: selecting toys appropriate to the child's age, interest, and mental and physical abilities; avoiding all toys made of lead or colored with lead-based paint; teaching and supervising children in the proper handling and potential dangers of specific toys, such as chemical sets, electrical toys, and bicycles; inspecting toys frequently to see whether misuse has rendered them unsafe; immediately repairing or discarding defective electrical toys.

In regard to toy construction, the committee recommends among other principles: building toys substantial enough to withstand investigation of construction by the user; one-piece construction for horns, whistles, and other toys used by small children; making toys for babies and toddlers washable, large, light in weight, and of nonbrittle material. The Toy Manufacturers Association has offered to publish articles on toy safety in its trade journals.

Members of the toy safety committee represent the Children's Bureau and the Public Health Service, U.S. Department of Health, Education, and Welfare; the American Academy of Pediatrics; the American Medical Association; two large insurance companies; a State health department; and the Girl Scouts of America; with the legal council of the Toy Manufacturers Association serving as liaison. The committee can be reached through the National Safety Council, 425 North Michigan Avenue, Chicago 6, Ill.

Professional Cooperation

Progress in achieving greater cooperation between the legal and the social work professions requires "programs of experimentation, study evaluation, and cooperative consultation" by appropriate National, State, and local organizations, according to a committee of lawyers and social workers appointed in 1956 by the Family Service Association of America to explore ways of improving relations between the two professions.

Among the difficulties the committee has found in the way of cooperation between the two professions in the interests of clients and community is the "linguistic barrier" set up when the lawyer uses too much legal terminology and the social worker too many terms drawn from the behavioral sciences and psychoanalysis. It also notes a frequent confusion on the part of social workers as to what is admissible evidence. Another item of difference between the two professions, according to the committee, lies in the fact that information given by the client to a lawyer cannot be used as testimony in a court proceeding, but that given to a social agency can. The committee urges bar associations and social agencies to devise measures for mutual reporting between lawyer and social agency of what happened in the client's case.

Among the sources of cases that use the services of both lawyer and caseworker, the committee points to marital conflict, which is likely to involve child custody; debt, which often disrupts families; and adoption, in which the legal rights as well as the personal welfare of the natural and the adoptive parents and the child need to be safeguarded.

As examples of successful cooperation between the two professions the committee calls attention to the work of legal aid societies.

The committee's findings are included in a pamphlet, "The Lawyer and the Social Worker," published by the Family Service Association of America, 215 Fourth Avenue, New York 3, N.Y. (Price, 65 cents.)

For Youth

The Chicago City Council recently enacted an ordinance creating a Commission on Youth Welfare to replace two official bodies, the Chicago Youth Commission and the Mayor's Advisory Committee on Youth Welfare. The new commission is charged with carrying out a comprehensive program for the welfare of youth in cooperation with "all public and voluntary agencies" engaged in providing services to youth and with promoting neighborhood councils. The council's actions resulted from recommendations made by the Mayor's advisory committee after a 2-year study of needs and services.

The ordinance makes it mandatory for all city departments to furnish the new commission with their services and information on request, and to reply in writing in regard to action taken on the commission's recommendations.

. . .

A 6-year experiment planned mainly to prevent juvenile delinquency in a specific area through a "saturation" of services, and to develop methods for doing the same thing in other places has been initiated in a section of New York's Lower Eastside by the Henry Street Settlement, with the cooperation of many other voluntary and public agencies serving young people. Represented on the board of trustees are five other Lower Eastside settlements, the Lower Eastside Neighborhoods Association, and the Lower Eastside Mission of Trinity Parish. The population of the project area, estimated at 115,000, includes 15 well-identified, highly delinquent gangs, according to James E. McCarthy, the project director.

Called "Mobilization for Youth," the project will: (1) supplement existing services with additional ones—psychiatric, psychological, casework, groupwork, educational, recreational, and others; (2) organize community and neighborhood leadership; (3) carry on social research through a separate unit. It is expected to cost $1,250,000 a year. Some funds have already been received and others are being sought from public and private sources.

Public agencies pledged to cooperate with the project include the city youth board; the board of education; the departments of health and welfare; the police department; the courts, including their probation departments; and correctional institutions.

The research unit of the project has been established under the auspices of the New York School of Social Work, Columbia University.

Premature Babies

Data collected during a study of the effects of a specific nursing practice on premature infants are being analyzed by the Division of Nursing Resources, Public Health Service.

Over an 8-month period the progress of 40 premature infants with a rolled diaper body support was observed and compared with that of 40 infants of similar sex, race, and birth weight who did not receive such support. The birth weights of the infants studied ranged between 1,000 and 2,000 grams.

Every 10 minutes, 24 hours a day, for the first 42 days of life, observers recorded each baby's sleep and vocal behavior, as well as body movements, and the type of care given and by whom (registered nurse or nurse's aid). Each baby's weight, body temperature, eating ability, caloric and fluid intake, and vomiting were recorded daily.

Preliminary review of the findings suggests that the diaper roll may contribute indirectly to the baby's welfare by increasing sleeping time and reducing crying, but that it does not contribute significantly to weight gain.

Facts and Figures

In 1958, for the first time since 1950, the number of infants born in the United States apparently decreased, according to provisional figures of the National Office of Vital Statistics. These indicate that about 4,248,000 babies were born in 1958, a decline of 53,000, or 1 percent, from the record high set in 1957. A reduction in marriages of 4 percent in 1957 accounts for one-fourth of the estimated decrease. The estimated number of first-born children who arrived in 1958 was 1,151,000, compared with 1,164,000 in 1957.

The provisional infant mortality rate for 1958 was 26.9 deaths of infants under 1 year of age per 1,000 live births; for 1957 the provisional rate was 26.4. Deaths of infants in the first month of life rose from an estimated 19.0 per 1,000 live births in 1957 to 19.4 in 1958.

. . .

In 1957, for the first time in about a quarter of a century, the maternal mortality rate in the United States failed to decline. That year the rate stood at 4.1 per 10,000 live births, the same as in the previous year. Maternal deaths in the country as a whole numbered 1,746 in 1957, as compared with 1,702 in 1956.

Between 1929 and 1956, the death rate among mothers due to complications of pregnancy, childbirth, and the puerperium steadily declined from 69.5 to 4.1 per 10,000 live births.

BOOK NOTES

INDUSTRIAL SOCIETY AND SOCIAL WELFARE; the impact of industrialization on the supply and organization of social welfare services in the United States. Harold L. Wilensky and Charles N. Lebeaux. Russell Sage Foundation, New York. 1958. 401 pp. $5.

This study of why and how welfare institutions and the profession of social work have developed in the United States—written by a professor of sociology and a professor of social work—is an extension of a monograph first prepared as a commission report for the Eighth International Conference of Social Work held in Munich in 1956.

Part 1 of the book discusses social problems caused by industrialization and urbanization from the days of the industrial revolution to the present, including discussion of the effects on the family of worker dependence on the state of the labor market, changes in the nature and bases of specialization, and the vastly increased mobility these impose on the worker.

Noting how the problems of industrialization have led to establishment of welfare services, Part 2 reports on the auspices and expenditures of existing services, discusses changing problems in family service, and analyzes various theories in regard to juvenile delinquency.

The authors point to two conflicting concepts of the function of social welfare institutions—the *residual*, which regards them as coming into play only when the normal structures break down, and the *institutional*, which regards them as normal "first line" functions of protection. They see family service as broadening to include a new clientele, the middle class; making increasing efforts to deal with problems of adjustment on a mass scale through social hygiene techniques; and being faced with the responsibilities of reaching families in far-flung suburbia.

Part 3 indicates how industrialization affects the organization of welfare services and describes the development of social work as a profession. The authors refer to the rise of hierarchal structure and of specialization in social work and their effects on service, the place of pressure groups in the formation of welfare policy, the withdrawal of board membership from involvement in day-by-day agency affairs, and the increasing control of fund-raising by the business world. They present some of the elements which delimit and define social work as a profession, and discuss the recurrent questions of the compatibility of professionalism with commitment to reform and what the proper relation of the professional social worker is to the policy maker.

THE PROBLEM OF DELINQUENCY. Sheldon Glueck, editor. Houghton Mifflin Co., Boston. 1959. 1,183 pp. $10.50.

Planned to assist in training prosecutors, judges, probation and parole officers, clinicians, social workers, and others in the field of juvenile delinquency, this book presents nearly 200 papers discussing the multiple forces and factors in the problem of juvenile delinquency. They are divided into four groups: on the incidence and causes of delinquency; the juvenile court and the law; treatment of the delinquent; and prevention of delinquency. A section is included on youthful offenders who are beyond juvenile-court age.

The authors represent a wide range of disciplines, such as social and physical anthropology, sociology, psychiatry, psychoanalysis, psychology, the law, and social work.

THE PSYCHOANALYTIC STUDY OF THE CHILD, Vol. XIII. Edited by Ruth S. Eissler and others. International Universities Press, New York. 1958. 582 pp. $8.50.

Included in this collection of theoretical papers and clinical reports are a number of discussions of the childhood psychological needs of the gifted, of normality and pathology in adolescence, and of the effects of early mother-child relationships on a child's personality development.

The volume includes 22 major papers, four of them, with following "discussions," from the Ernst Kris Memorial Meeting, held in 1957 in New York by the New York Psychoanalytic Society and Institute and the Western New England Society and Institute. The remaining papers are divided into four sections: "Contributions to Psychoanalytic Theory," "Aspects of Normal and Psychoanalytic Development," "Clinical Contributions," and "Applied Psychoanalysis." The book also includes a list of the writings of Ernst Kris and the tables of contents of the 12 previous volumes.

NUTRITION IN HEALTH AND DISEASE. 13th ed. Lenna F. Cooper, Edith M. Barber, Helen S. Mitchell, and Henderika J. Rynbergen. J. B. Lippincott, Philadelphia. 1958. 734 pp. $6.

The new edition of this textbook for students of nursing includes some changes of special interest to child-health workers, notably in the chapter dealing with nutrition in diseases of infancy and childhood. Without shifting the focus from the sick child to his illness, the authors have introduced additional material on the nutritional problems of crippled children and have also dealt briefly with the recently recognized inborn errors of metabolism that if untreated are likely to result in mental deficiency.

MENTAL SUBNORMALITY; biological, psychological, and cultural factors. A survey of research sponsored by the National Association for Retarded Children. Basic Books, New York. 1959. 442 pp. $6.75.

This book includes two reports, previously published separately, "The Prevention of Mental Subnormality" by Richard L. Masland, M.D., and "Psychological and Cultural Problems in Mental Subnormality" by Seymour B. Sarason, psychologist, and Thomas Gladwin, anthropologist. (See CHILDREN, May–June 1958, page 115.) The first report reviews studies concerned with the physical causes of mental retardation—genetic, intrauterine, and postnatal; and the second, studies concerned with the cultural and environmental factors in mental retardation.

IN THE JOURNALS

Intercountry Adoptions

How a U.S. Army hospital in West Germany works with a German child-placing agency to safeguard children and adoptive parents in the placement of children with American Army couples is reported by the hospital's psychiatric social worker in the March 1959 issue of *Social Casework.* ("Casework Consultation in Overseas Adoption," by Frank F. Montalvo, First Lieutenant, U.S. Army.) The program was begun after hospital authorities learned about the mistreatment of some adopted children by severely disturbed adoptive parents and of other children being placed for adoption who were severely disturbed themselves.

Now, according to the author, the local agency requires every American couple applying for a child to obtain from the Army hospital a certificate stating that the two are in good mental and physical health and that they have received "preadoptive counseling." Before the adoption takes place the hospital pediatrician examines the child to discover any conditions that might interfere with his later development.

Respiratory Illnesses

A newly recognized group of viruses, known as hemadsorption viruses, apparently are responsible for 50 percent more cases of acute respiratory disease among infants and children than is influenza, according to the findings of a study carried out by the Public Health Service's National Institute of Allergy and Infectious Diseases and the Research Foundation of Children's Hospital in Washington, D.C.

The study included examination of throat swabs from 1,738 hospitalized children of low-income families during 1957–58, including patients with respiratory illness and controls, and found two strains of the hemadsorption (HA) viruses associated more frequently with the sick children. Type 1 was associated most frequently with pneumonia, croup, bronchiolitis, pharyngitis, and mild respiratory tract disease; type 2 with croup, pharyngitis, and the mild illness, with croup showing the highest rate of association. The HA viruses were shown to be responsible for about 20 percent of the total respiratory illnesses studied, and for 42 percent of the croup cases.

The techniques of the study were reported in detail in the February 7, 1959 issue of the *Journal of the American Medical Association* by the seven investigators involved.

Institution Administrator

The first responsibility of a children's institution is to give each child the opportunity to establish roots, even if only temporarily, in an atmosphere created by warm, affectionate persons who can fulfill his needs for love, security, and understanding, says Helen R. Hagan, assistant executive director of the Child Welfare League of America, in *Child Welfare* for March 1959. ("The Administrator's Responsibility: Developing Program To Meet Varying Needs of Children.") Among other needs the institution must try to fulfill for children, she cites the need for satisfaction through accomplishment, for experience of the world outside the institution, and for treatment of problems interfering with normal development.

The administrator must assume the role of leader in fulfilling these needs, says the author, identifying in this role a number of specific functions: the accountability for a total program of individual and environmental treatment; the recruitment, screening, employment, orientation, and retention of properly qualified staff in various disciplines and evaluation of their work; the establishment of channels of communication among the staff, between staff and administrator, and between administrator and board and community.

Maintaining that other types of child welfare services in the community obviate the need of institutional care for "normal" little children, she points out that other children desperately require types of institutional services that are not sufficiently available—the physically handicapped child who needs special training, the mentally retarded, the emotionally disturbed, and the adolescent who cannot get along in a foster family.

Accident Prevention

Doctors, hospitals, and medical societies should carry on a steady, year-round program for educating parents in accident prevention, says Forrest P. White, M.D., in the *Virginia Medical Monthly* for March 1959. ("The Physician's Responsibility in Childhood Accident Prevention.") Warning against the kind of program which might cause parents to develop such neurotic concern that they constantly hover over the child, he advocates encouraging them to make the environment so safe that they can relax in the reasonable assurance that their children will not be injured.

Recognizing, however, that there are times when vigilance is needed, the author also urges physicians to teach mothers about the dangers in such practices as holding a lighted cigarette and a baby at the same time or leaving the baby in a bathtub while answering the telephone.

One-Parent Families

A 5-year group discussion project enabling widowed and divorced parents to exchange views on the problems of bringing up their children is described in *Social Work* for January 1959 by Kurt Freudenthal ("Problems of the One-Parent Family"). The discussions, sponsored by the Baltimore Board of Education and led by the author, a social worker, were carried on in 30 weekly sessions each school year. An average of 50 parents, three-fourths of them mothers, participated.

Several factors in one-parent families were noted frequently, says the author, which involved both parent and child: a sense of incompleteness and frustration; a sense of guilt and failure; and mixed feelings of hostility and love toward each other.

The author suggests the possibility of conducting similar group sessions for parents receiving assistance payments under programs for aid to dependent children and special emphasis in inservice training of ADC workers on the problems of the parent who is bringing up a child or children alone.

Readers' Exchange

STITT et al.: ***Some questions***

In their description of the Family Health Clinic in Boston, Dr. Stitt and her colleagues emphasized a stimulating point when they maintained that the pediatrician can be more effective in his help to mothers if he becomes acquainted with them during the prenatal period. [See "Teamwork in Helping Families To Launch a Life," by Pauline G. Stitt, Joan G. Babbott, and Eva J. Salber, CHILDREN, March–April 1959.]

However, in respect to their aim of bridging the gap between the obstetric and the pediatric phases of family health counseling, they failed to discuss what is probably the most critical period to most mothers—the days in the hospital and the first weeks at home—a time when the pediatrician has a unique opportunity for carrying a desperately needed supporting role. This is relevant to the philosophy expressed by the authors in phrases such as "timely measures," "sense of the moment," "the crises of pregnancy and child rearing," and "the way in which each new challenge is met has immediate and long-range effect." I hope the day will soon come when a home visit by a physician will be a routine feature during the first week or two of the baby's life.

Since a clinic is not really a "family clinic" if the fathers are not successfully involved, Dr. Stitt and her colleagues more properly referred to the service they describe as an "obstetric-pediatric clinic." In certain countries, the term "puericulture center" is used. It is impracticable in this country and probably inadvisable to establish the type of family clinic organized in some parts of the world under WHO demonstrations where entire households, including fathers and grandparents, can go for all their medical needs. But we should at least be able to schedule practice, private or clinic, to include an evening or Saturday morning group discussion among fathers.

Mothers often have charged that pediatricians tend to dispense advice as if the one child under discussion at the moment is their only child. In mentioning the undesirability of "overelaborate attention to one child," Dr. Stitt and her colleagues whet our appetites for more details on how "practices geared to stages in children's motor, social, and adaptive development" can be established in the family that includes several children, each in a different stage of motor, social, and adaptive development.

In closing, the authors recognize that varying amounts and components of the clinic described might be adapted to other settings. Many questions remain to be answered: Is the multidisciplinary approach feasible or desirable as the general pattern of family counseling? To what extent should the various disciplines give direct service, and how many of them might preferably join the psychiatrist in a consultant capacity? When does the law of diminishing returns set in in the advantages that accrue to the members of the team from their association with each other? Other than in a research and training situation, would the cost per family not be prohibitive? Would it not be desirable to use general practitioners, so that at least the medical components could be unified in one individual who would have access to obstetric, pediatric, and psychiatric consultants?

Samuel M. Wishik, M.D., Professor, Maternal and Child Health, Graduate School of Public Health, University of Pittsburgh.

Lucky families

The value of the type of multidisciplinary experience described by Dr. Stitt and her coworkers in furthering mutual respect and understanding among the various professional disciplines is self-evident. Exposure to such a concentrated family-centered setting early in the period of graduate training should do much to promote favorable career-long working relationships among members of the various professions represented on the team.

The families seen at the Family Health Clinic are fortunate indeed. Only 116 families having their first babies and 25 of the same families during and after subsequent pregnancies were seen at the clinic over a 6-year period. Even if the clinic met only once a week, this would represent a tremendous concentration of high-powered personnel time. This is hardly a demonstration service in the sense of setting a pattern that might be followed even partially in a public maternal and child health program. The concentrated approach should be considered only as a research or training situation.

Since the focus of the article is on the pediatrician's contribution to family-centered care, the place of the obstetrician remains rather obscure. It would be of interest, for example, to know how long the obstetrician functions as a member of the team after the birth of the infant. No mention is made in the article of the management of delivery itself and whether or not there is any carryover from the clinic to the hospital delivery and postpartum experience. Lack of involvement of the clinic obstetrician and pediatrician in the hospital would leave a serious gap in the continuum of care.

Edward R. Schlesinger, M.D., Associate Director, Division of Medical Services, New York State Department of Health.

WERTHEIM: ***More about fathers***

In commenting on my article "A Joint-Interview Technique With Mother and Child" [CHILDREN, January–February 1959], J. McV. Hunt asks: "What about fathers?" [CHILDREN, "Readers' Exchange," March–April 1959.] On theoretical grounds, where the family is basically intact, the inclusion of fathers and sometimes siblings would be the approach of choice. The limitation of the joint interview to the mother and child as described in the article was due at the time to practical difficulties in bringing the fathers to the clinic for frequent sessions. In most cases a close contact with the fathers was maintained with occasional joint family or parent interviews. The handling of the total field of family relationships proved clinically superior to dealing with a limited sector only.

The mother-child dyad was made the focus of the report because the dynamics of this combination in a clinical setting had been explored more fully than the total family group. The observations described were derived from daily clinical experience. Systematic evaluations properly sought by Professor Hunt are not yet available. The challenging possibilities evident at this exploratory stage seemed to warrant a report in order to stimulate research and thinking.

As Professor Hunt pointed out, in spite of the advantages of family group therapy, in certain situations a joint interview including only mother and child may be the technique of choice. He added, "but it will be difficult to discover what these situations are without first focusing on the family as a unit."

Although therapeutic influences are implicit in the diagnostic process, I would like to emphasize at this point the importance of diagnosis per se which Professor Hunt seems to minimize. Sound diagnosis is essential in setting therapeutic goals and deciding form of treatment. It must include consideration of which family members should be involved in treatment and at which point in time. Further, it calls for a careful evaluation of the desirable and the undesirable changes the treatment is likely to produce in the total family equilibrium. The stress in the article on the diagnostic aspects of the joint-interview technique reflected this view. Improvement of diagnostic knowledge and techniques is a necessary prerequisite to a more differentiated approach to therapy.

Eleanor S. Wertheim, Clinical Psychologist, Royal Children's Hospital, Melbourne, Australia.

Guides and Reports

THE ECOLOGY OF THE MEDICAL STUDENT; report of the Fifth Teaching Institute, Association of American Medical Colleges, Atlantic City, N.J., October 1957. Edited by Helen Hofer Gee and Robert J. Glaser. Part 2 of the *Journal of Medical Education*, October 1958. The Association, Evanston, Ill. 262 pp. Cloth, $3; paper, $2.

Presents discussions exploring the environmental stresses that influence the development of the future physician.

NATIONAL HEALTH COUNCIL DIRECTORY OF MEMBER ORGANIZATIONS, 1958. The Council, 1790 Broadway, New York 19, N. Y. 124 pp. $1. Special rates for quantity purchases.

Describes the purposes, program, organizational structure, publications, and source of financial support of each of 63 national public or private health agencies.

INTEGRATION—A CHALLENGE TO THE SOCIAL AGENCY; report of a workshop, June 11, 1958, sponsored by Committee on Intergroup Relations, National Social Welfare Assembly. The Assembly, New York 17, N.Y. January 1959. 25 pp. 75 cents. Quantity discounts.

At this workshop representatives of more than 30 national voluntary social agencies examined ways in which they could help their local affiliates work for racial integration within themselves and their wider communities. (See CHILDREN, September–October 1958, p. 196.)

THE CHILD AT LAW; report of the 28th Ross Pediatric Research Conference. Ross Laboratories, Columbus 16, Ohio. 1958. 104 pp. Free on request from Ross Laboratories.

Proceedings of a symposium held in 1958 at Tulane University, New Orleans, attended by representatives of pediatrics, social work, psychiatry, education, the ministry, and the law, focused on the legal aspects of the family, guardianship, adoption, delinquency, foods, drugs, and accidents, in relation to children.

REACHING OUT IN RECREATION; a practical guide to human relations techniques. Jay B. Nash, Milo F. Christiansen, and Dan W. Dodson. School of Education, New York University, Washington Square, New York 3; and Division of Youth Services, American Jewish Committee, 386 Fourth Avenue, New York 16, N.Y. 1958. 20 pp. 20 cents. Quantity prices on request.

Presents real-life problems involving integration of minority and majority groups in public recreation programs and describes efforts to solve them; also lists 12 guidelines for leaders in situations involving groups of different backgrounds.

THE NONOPERATIVE ASPECTS OF PEDIATRIC SURGERY; report of the 27th Ross Pediatric Conference. Ross Laboratories, Columbus 16, Ohio. 1958. 96 pp. Free on request from Ross Laboratories.

In addition to technical discussions of procedures, this report of a conference held in 1957 at the Ohio State University College of Medicine, Columbus, Ohio, includes discussions of preparation of a child for surgery, his emotional reactions to surgery, and play programs for the hospitalized child.

THE LITTLE BOY WHO HAD TWO BIRTHDAYS. Martha Helen Sullivan. St. Anthony Guild Press, Paterson, N. J. 1958. 12 pp. 35 cents.

A story for children of a happy adoption, written as an aid to parents in helping an adopted child understand and feel good about the fact of his adoption.

YOUTH IN COMMUNITY AFFAIRS. National Social Welfare Assembly, 345 East 46th Street, New York 17, N. Y. 1958. 15 pp. 20 cents in lots of 25 or more; 25 cents a copy.

A summary of discussions that took place at a 4-day meeting of 60 boys and girls 15 to 19 years of age, which was called at New York by the National Social Welfare Assembly this year to bring out the young people's opinions on teen-agers' participation in community affairs.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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MORE THAN BREAD; social services in public assistance, a community resource. Helen C. Manning. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. 1958. 24 pp. 15 cents.

Addressed to community leaders, members of civic groups, and other citizens, this publication uses case stories to show how social services in public assistance help recipients of public aid solve their difficulties. It describes some projects that demonstrate the values of adequate welfare and tells how people can help make them available in their communities.

CHILD-CARING INSTITUTIONS—THEIR NEW ROLE IN COMMUNITY DEVELOPMENT OF SERVICES. Martin Gula. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 368. 1958. 27 pp. 15 cents.

Addressed both to communities and to institutions, this publication notes that social, economic, and medical changes have affected families and communities in the past few decades and have led to changes in child care; points out principles on which communities may decide whether a troubled child can best be helped at home, or in a foster family home, or in an institution; and suggests guides to help modern institutions provide the services each child needs. Twenty "marks of a good institution" are included.

FALL 1958 STATISTICS ON ENROLLMENT, TEACHERS, AND SCHOOLHOUSING—in full-time public elementary and secondary day schools. Samuel Schloss and Carol Joy Hobson. Department of Health, Education, and Welfare, Office of Education. Circular No. 551. 1959. 18 pp. 20 cents.

Public school enrollment in this country was approximately 1,843,000 over the normal classroom capacity of the public elementary and secondary schools when the current school year began, representing 5.4 percent of the total enrollment, according to this report. These total figures represent a slight lessening of classroom overcrowding in comparison to those for the previous year, when the excess enrollment represented 5.9 percent of the total enrollment. However, 18 States and the District of Columbia reported an increase in excess enrollment. The number of pupils being taught by teachers with substandard credentials is estimated at 2,649,000—or 7.8 percent of the total enrollment.

YOUR GIFTED CHILD. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 371. 1958. 39 pp. 20 cents.

Offers suggestions to parents who wish their gifted child to develop to his fullest and live a happy and productive life. The manuscript was reviewed before publication by more than 100 persons, including parents, gifted children, individual educators and representatives of the National Association for Gifted Children, the Association for Childhood Education International, and the U.S. Office of Education.

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DEPOSITORY

JUST ARRIVED, this child has a life expectancy of 66.3 years. His most dangerous days, however, lie just ahead, for the death rate in the first month of life is greater than in any other period except in old age. Factors in the death or damaging of children before, during, or just after birth are discussed, along with possibilities for prevention, in the lead article in this issue.

◀ the authors

On publication of his book "Perinatal Losses in Modern Obstetrics" 2 years ago, Robert E. L. Nesbitt, Jr., was designated by the U.S. Junior Chamber of Commerce as one of the 10 outstanding young men in America. Before going to Albany in 1956, he was chief of obstetrics in the pathology laboratory of Johns Hopkins Hospital and acting head of the hospital's department of obstetrics. He has reported extensively in medical journals on his researches on pathologies in pregnancy and the causes of fetal and infant deaths.

In the 13 years since she joined the staff of the Boys Industrial School in Topeka—with the promise to stay a year—Leita P. Craig has been active in the development of the treatment program there. Previously she was on the staff of the Kansas Receiving Home for Children in Atchison. She has also been an elementary school teacher and a principal in the Atchison public school system.

Pediatrics was Geoffrey Martin's chosen field until he went to Kansas in 1947 to work in a child health demonstration unit out of "curiosity" about public health. He stayed to become assistant director and then director of the State division of maternal and child health, and then, a year ago, State health officer. He was previously assistant in pediatrics at the Johns Hopkins' medical school.

Trained professionally in both education and social work, Sara-Alyce P. Wright has been in YWCA work for the past 12 years—for 4 of them in Youngstown, Ohio, where she was program director of the local "Y," and for the past 8 at national headquarters, where she carries special responsibility for the development of program for young people between the ages of 12 and 18. She is chairman of the youth services committee of the National Social Welfare Assembly.

Before coming to the Children's Bureau in 1950, Catherine E. Harris was for 3 years in the Office of Education, 2 of them spent in research and statistics. During the war she worked in the Colorado River center of the War Relocation Authority in various capacities—employment registration, public assistance, high school teaching. She has also taught in high schools in and near Chicago.

While directing the delinquency project for the National Education Association, William C. Kvaraceus is on leave from Boston University, where he is professor of education. Creator of the KD proneness scale and checklist for attempting to identify delinquency susceptibility in children, he is also engaged in a 3-year research project on prediction of juvenile delinquency, sponsored by the U.S. Office of Education.

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PERINATAL CASUALTIES

ROBERT E. L. NESBITT, JR., M.D.
Professor and Chairman, Department of Obstetrics and Gynecology, Albany Medical College of Union University, Albany, N.Y.

THE PERIOD of human existence between the end of the 19th week of gestation and the end of the first month of postnatal life presents a greater hazard to the individual than any other period from then until old age. The magnitude of the problem is illustrated by the fact that deaths of viable fetuses and newborn infants make up about 10 percent of all deaths occurring in the United States today.

As great as these losses are, they represent only a part of the total problem of casualties associated with birth. It is now abundantly evident that the factors responsible for dead fetuses and infants and those responsible for damaged infants are very much the same. Thus, there is an aftermath or "continuum" of the birth process that is of grave concern. Infants with sublethal injuries may develop a number of potential and real neurological sequelae, including epilepsy, mental deficiency, cerebral palsy, and even abnormal behavioral patterns appearing in later childhood.

Any definition of casualties connected with birth process must be sufficiently broad to encompass a wide spectrum of events, including fetal death in utero at all stages of gestation, death of liveborn infants during the first month of life, malformation, and permanent disability because of some type of injury before, during, or immediately following the birth process. The period of time covering the total birth process is referred to as the perinatal period, and mortality and morbidity incurred by fetuses and infants during this span of human existence are designated as "perinatal casualties."

The concept of a perinatal period is useful in many ways, but because it has been only recently widely employed there has been confusion about the time period involved. The definition proposed by the American Medical Association—from the 20th week of gestation through the 28th day of life—is receiving wide acceptance.

In a total appraisal of reproductive wastage, however, it is necessary to consider the loss of products of conception at any stage after the union of the two pronuclei in the fertilized ovum, as well as the antecedent genetic and environmental background of the mother. Patients who have experienced reproductive failure frequently have a similar etiologic background with patients showing infertility, pathologic manifestations of menstruation, and other gynecological disorders.

The recurring nature of these interrelated problems explains the fact that about one-fourth of all patients experiencing reproductive losses account for nearly two-thirds of all the losses.[1] The incidence of previous gynecological symptoms in these women is high, indicating that preconceptional care is an integral part of obstetric care. Such care or its lack has a direct influence upon the incidence of perinatal casualties, both immediate and remote.

A condensation of three papers presented at the Institute on Perinatal Casualties, sponsored by the schools of public health of the University of Michigan and the University of Minnesota, Minneapolis, December 8–13, 1958. The full papers, containing considerably more medical material, appear in the proceedings, just published by the Center for Continuation Study of the University of Minnesota. Single copies from the Center on request.

Clearly then, any thorough appraisal of the problem of perinatal casualties requires a multidisciplinary approach. Attacking the problem of fetal and maternal welfare must be part of the general health program and cannot be relegated to any single group of medical scientists. The problem is primarily one of community health. It involves medical scientists, clinicians, nurses, and public or community health workers; and through its relation to socio-economic status, it becomes the concern of demographers, nutritionists, sociologists, economists, political scientists, and, of course, the general public.

Extent of Problem

Perinatal casualties do not lend themselves to precise summation, but they are believed to exceed 900,000 annually in the United States.[2] This estimate includes disability immediately or subsequently apparent as an aftermath of the birth process as well as the mortality in the perinatal period.

Since reliable figures on morbidity and remote sequelae do not exist, advances in coping with the problem must be judged from mortality statistics, available from the Public Health Service's National Office of Vital Statistics. Between 1933, the first year for which such statistics are available for the Nation as a whole, and 1956, the infant mortality rate (deaths under 1 year of age) dropped 55 percent. All age groups shared in the reduction but in differing degrees, the greatest reduction occurring in the age group 6 to 11 months and the least in the group under 1 day, at 1 day, or 2 days old.

Despite reductions, deaths in the perinatal period still represent an enormous loss of human life. Today deaths of viable fetuses and newborn infants come to about 165,000 each year in the United States. An even larger number of deaths, approximately 425,000 annually, occur as spontaneous abortions in the previable stages of pregnancy.[3] There are indications too that the sharp decline in perinatal losses which took place during the years 1935 to 1945, an era of rapid medical and social progress, has gradually leveled off during the present decade.

Although premature birth occurs in less than 10 percent of all pregnancies terminated after the period of fetal viability, prematurity is associated with more than one-half of all perinatal deaths. In New York State at the present time about 60 percent of the fetal deaths of more than 20 weeks' gestation and about 75 percent of the 6-day postnatal deaths occur in fetuses or infants weighing 2,500 grams or less at delivery. In upstate New York, during the period 1945–54, the neonatal mortality rate adjusted for birth weight declined by more than 30 percent, but the greatest decline occurred among the larger infants. No decline occurred among infants weighing less than 1,000 grams.[4]

Role of Vital Records

Many public health agencies are attacking the problem of perinatal loss, through the continuing analysis of the data available from fetal, maternal, and infant death certificates and livebirth certificates. A major objective in such analyses is to show where knowledge is lacking in order to stimulate further research and study.[5] Although there are important sources of data in hospital material, or from obstetrical-statistical cooperatives, a multidisciplinary attack on perinatal losses requires the exertion of every effort to correct deficiencies in the procurement and tabulation of data from vital records.

Indications are that the quality of death certificate data for perinatal deaths could be improved by a more intensive study of available clinical records and by use of data on pathological conditions, especially in assigning causes of death during the neonatal period. A recent study found that in 40 percent of the fetal and infant death certificates submitted to the Baltimore City Health Department by a hospital, the cause of death given failed to agree with the cause given on a special certificate based upon careful study of the findings on clinical and pathological conditions and the comments of a committee of medical experts.[6]

A comparison of the percentage distributions of the causes given on the special and other certificates showed the following:

1. Fetal deaths were ascribed to causes and conditions in the mother about twice as often on the special certificates as on the others.

2. The frequency of causes determined in fetus, placenta, and cord was about the same on the different sets of certificates.

3. Fetal deaths were ascribed to unknown or ill-defined causes less frequently on the special certificates than on the others.

For neonatal deaths agreement between the special and original certificates was only 46 percent, excluding the rubric, hyaline-like membrane disease, which was not used when the original certificates were coded. Infection of the newborn was also found more frequently on the special certificates than on the others.

To evaluate properly the frequency of specific causes of perinatal death or to compare perinatal mortality rates, one must know the incidence of such multiple factors as race, parity, age, economic class, and the proportion of maternal complications in the respective population samples. These factors are highly interrelated and are associated significantly with the infant's birth weight as well as the general reproductive outcome.

The Etiology

The determination of the causes of perinatal death is subject to peculiar difficulties. All methods of classification thus far devised have failed in one way or another. Present knowledge concerning maternal, fetal, and placental factors is not sufficient in all instances to identify and separate the specific causes. Almost one-third of all perinatal deaths are unexplainable through current study technics.

The underlying cause of perinatal death often does not reside within the infant's body and so cannot be determined by autopsy alone. It may reside in the mother or in the placenta.

In recording each death every effort should be made to determine the underlying cause. If the cause is indeterminable, it is preferable to ascribe the death to unknown causes than to the ultimate clinical or pathologic condition. Certain fetuses and infants with insignificant pathologic findings may have been insulted by anoxia or trauma over a short period of time without being left with detectable signs. It is especially difficult to classify such cases when the clinical records are deficient. Any measure of success in determining the primary pathologic cause of death depends upon the correlation of a detailed pathologic examination with a reliable obstetric and pediatric history.

The initial stages of standardization of technics, clarification of definitions, and classifications of death are indispensable to the task of reducing perinatal losses. Granting that there are serious limitations in our current classifications, they have nevertheless exposed the problems that need concentrated study.

Classifying Causes

Several large independent studies of perinatal mortality have pointed out the same major causes of death and have estimated their incidence in relatively the same order of importance.[7,8,9,10]

The opinions concerning the relative frequency of various specific causes of perinatal mortality expressed in the following paragraphs are derived in large measure from the studies of Nesbitt and Anderson,[7] carried out on clinical and pathological material from the Johns Hopkins Hospital.

Anoxia. Anoxia is responsible for more deaths in the perinatal period than any other etiologic factor. It may be considered the primary cause of death when interference in the supply of oxygen from mother to fetus has produced structural changes in the fetus or infant visible at autopsy. It may be derived from a variety of factors—the placenta, cord, maternal diseases, difficult labor, and other complications.

One-third of all perinatal deaths in obstetric departments that care for a high percentage of indigent patients are attributable to anoxia. Moreover, anoxia is the principal common denominator between dead and handicapped infants, only a matter of degree and duration of insult determining whether the infant is killed or merely damaged.

Birth Injury. Deaths from birth injury include deaths of fetuses and infants who die as a direct result of injury during the mother's labor or delivery, usually intracranial injury, and of those who die from intracranial lesions initiated by anoxia. Such injury is the cause of slightly less than 10 percent of the total number of perinatal deaths. In about three-fourths of such cases there has been some type of significant maternal complication. Intracranial lesions and hemorrhage attributable to anoxic injury are much more common in premature than in mature infants.

Malformation. Malformations incompatible with life are responsible for about 9 percent of all perinatal deaths. The incidence of malformations as a cause of death is much more common in premature than in term infants. There is a close etiologic relationship between malformations and a variety of reproductive problems, including fetal death, both early and late, certain neonatal complications, premature birth, and habitual abortion. Available evidence suggests that a faulty maternal organism is the common factor that creates an unfavorable intrauterine environment for the fetus. Only a small minority of these abnormal obstetric events seem to be genetically determined.

Abnormal Pulmonary Ventilation. The problem of respiratory insufficiency in liveborn infants in the first several days after birth includes immature lung tissue and hyaline-like membrane disease. Hyaline-like membranes in association with pulmonary atelectasis (imperfect expansion of the lungs) are found in a large group of cases with abnormal pulmonary ventilation, which ranks high as a causative factor in neonatal death, particularly among premature infants. Nearly one-fourth of all deaths of premature infants during the neonatal period are attributable to pulmonary pathology.

A number of obstetric factors are associated with the incidence of hyaline-like membranes in the newborn. These factors are premature birth, maternal diabetes, and delivery by Cesarean section. The incidence is also increased in association with breech delivery, multiple delivery, and maternal toxemia, but it seems likely that a high incidence of premature birth in these conditions may account for this finding:

Infection. Considerable attention must be directed to all clinical and pathologic findings in ascribing infection as a sole cause of death, since infection, particularly pneumonitis, is a terminal finding in many infants dying of other conditions. Deaths that are properly classified as caused by infection should have infection reported as the underlying cause, not merely as an ultimate complication. Infection as a primary cause of death assumes major importance as a cause of death in the postneonatal period, but it accounts for only about 5 percent of the total perinatal deaths.

Pneumonia occurring within the first few days of life as a result of intrauterine infection is a rather frequent finding in term infants. Long labors, prolonged rupture of membranes, particularly when the fetus is of term size, and intrapartum fevers are often associated with contamination of the amniotic fluid with bacteria.

Septicemia also occurs in infants on rare occasions. Although still a relatively minor cause of perinatal mortality, outbreaks of infections due to penicillin-resistant staphylococci are becoming more frequent.

Erythroblastosis. Hemolytic disease of the fetus and newborn infant, caused by Rh factor incompatibility in the parents, is a relatively minor specific cause of perinatal death because of its comparatively low incidence. Moreover, there are striking differences in the incidence among the races. It is responsible for only one perinatal death in about 1,500 births in obstetric clinics caring for large numbers of Negro patients. In hospitals where the clinic population is predominantly white it occurs approximately three times as often or about 1.8 per 1,000 births.

Other Conditions. Apart from the major categories of perinatal death, there are occasional conditions which counted together are responsible for less than 1 percent of all perinatal deaths. They include such unrelated conditions as advanced ectopic gestations, fetal hydrops (accumulation of fluid) of unknown cause, congenital tumors, marked increase in intracranial pressure without evidence of intracranial lesions at autopsy, placental infarction, and complications of the umbilical cord.

No Abnormal State. After classifying perinatal deaths in accordance with these major categories, there remains a substantial number of deaths, perhaps as many as 30 percent of all, without demonstrable lethal factors to explain them. The great majority of such cases are fetal deaths in utero, usually occurring before labor. About one-fourth of these fetuses have been delivered of mothers having significant maternal disease, usually toxemia or diabetes. Improved technics for the study of tissue antibodies (fluorescent microscopy) and of viral infections may decrease the number of unexplainable perinatal deaths.

Prematurity and Abortion

Prematurity should not be listed as a specific cause of perinatal death, although certain of the aforementioned causes of death are more commonly seen in premature infants. The major factors in perinatal death of premature fetuses and infants, in descending order of importance, are placental complications, abnormal pulmonary ventilation, toxemia, birth injury, malformation, and infection. However, the impact of the factor of prematurity upon neonatal mortality is evident in all of the specific causes of death. When birth weight is taken into account the death risk of liveborn infants born to mothers with placenta previa is 2½ times that of liveborn infants born to mothers with no obstetric complications, whereas if birth weight is not taken into account the risk is 13 times as great. Similar observations have been made in regard to abruptio placenta.

Although much is known of the physiology and pathology of early abortion, an understanding of the etiologic factors involved has lagged far behind advances in other areas of obstetrics. A multiplicity of mechanical, clinical, physiological, psychological, and endocrinological factors have been implicated as causes of repeated abortion. These factors may be considered under the rather broad heading, "faulty maternal environment." It has become increasingly apparent that faulty environment for the developing ovum and fetus may be a factor common to a broad spectrum of specific types of fetal wastage, including early and late fetal death, premature birth, and malformation. Thus, it is important to subject patients who have demonstrated any one of these specific types of reproductive failure to careful study.

Great voids obviously exist in the understanding of many of the basic principles involved in perinatal loss. Autopsies must continue to be energetically sought, and emphasis must be placed upon the acquisition of better clinical materials.

Morbidity

The factors responsible for dead infants and the factors responsible for live but damaged infants are very much the same. Most studies show that premature birth, birth injury, third-trimester bleeding, placental complications, advanced maternal age, and intrapartum infection are frequent antecedents to delivery of infants with permanent neurological damage.

Eastman and DeLeon[11] report that 78 of 96 cerebral palsied infants subjected to careful study were born to mothers who had significant maternal complications. This study tends to add additional support to the growing opinion that anoxia incurred perinatally is a major cause of cerebral palsy and other neurological sequelae. Current and prospective studies should offer a clue to the precise etiologic factors and to measures for prevention.

Factors in Prevention

The prevention of perinatal casualties is a joint responsibility of several health disciplines, including obstetrics, pediatrics, anesthesiology, nursing, hospital administration, and public health. The adoption of a multidisciplinary approach to the problem of perinatal casualties represents the *initial step* in its solution.

The *second major factor* in prevention is the wider application of what is now known about patient care. It is not always necessary to know the finite causes of disease or death in order to take effective measures to control them. Maternal toxemia is a classic example. It has been stated that meticulous prenatal care is likely to eliminate toxemia as a maternal complication before its precise etiology is understood.

Statewide statistics do not make clear the fact that some counties within the State may have rates far in excess of the mean perinatal mortality rate for the State. Such differences call for a look at differences in services.

The *third major factor* in prevention is the elevation of living standards among the underprivileged classes. Low standards of obstetric care, low standards of living, and ignorance go hand in hand. Measures directed toward providing adequate facilities, personnel, and lay education have a positive influence on perinatal losses. Better nutrition and housing, good sanitation and adequate financial resources to ensure a decent livelihood, equal opportunity for education, and expanded social rehabilitation are necessary tools in the reduction of premature birth and to greater fetal and neonatal salvage.

Preconceptional Care

There is reason to believe that correction of all demonstrable medical, endocrinologic, and other kinds of defects, including emotional problems, prior to and during pregnancy, will enhance the probability of fetal salvage. The outlook for patients who have a recurring factor responsible for a high rate of reproductive waste, particularly habitual abortion, may be considerably improved by appropriate therapy prior to conception. Thus, a *fourth factor* in the prevention of perinatal casualties is preconceptional care.

Specific and supportive therapy in chronic illness, attention to the patient's diet, hygiene, habits, and psychological status, and the correction of endocrinologic and anatomic defects are important. Public health agencies should support this broadened concept of obstetric care by developing community "preconceptional" clinics set up to evaluate women who have demonstrated reproductive problems.

Professional and lay education is a *fifth major factor* in prevention of perinatal losses. Public health agencies can assist the obstetrician immeasurably by offering courses of instruction, medical films, teaching aids, and a continuous educational program for expectant mothers. Medical centers can join with other health agencies in providing professional programs of postgraduate education for practicing physicians, intramurally or extramurally. A technic which has proved valuable is the perinatal conference, in which fetal and neonatal deaths are discussed by obstetricians, pediatricians, pathologists, anesthesiologists, and other interested physicians.

A continuing analysis of perinatal mortality and morbidity at the local level is imperative. Since the problems associated with reproductive wastage vary greatly from one community to another, effective preventive health programs in one area may not be directly applicable in another. Thus, the establishment of perinatal mortality conferences on a community-wide basis is desirable.

Obstetric Management

A *sixth major factor* in prevention is the evolution of a clinical attitude in obstetrics which emphasizes conservative technics of management as a means of avoiding anoxia and trauma.

Fortunately, in the majority of cases, the obstetrician can anticipate the underlying problem of intrauterine anoxia and so prevent or minimize it by proper obstetric management. When the fetus is subjected to anoxia from unavoidable maternal complications, an avoidance of multiple insults to the fetal respiratory center should be the primary objective during labor and delivery.

Space does not permit a detailed account of the management of specific obstetric complications. Suffice to say that dissemination of current knowledge concerning conduct of premature labor, judicious use of analgesic and anesthetic drugs, antepartal prophylaxis against toxemia, prompt recognition and treatment of medical illnesses, attention to and supplementing of diet, proper attention to iso-immunization, induced labor prior to term in selected cases, surrounding patients with safeguards of blood replacement and appropriate chemotherapy, proper evaluation of the pelvis, judicious use of uterine stimulation, and expert resuscitation and care of the newborn infant will do much to assure optimal perinatal salvage.

With few exceptions, the longer the fetus can remain in the uterus the better are its chances of extrauterine survival. Certain medical advances in the management of specific medical illnesses, such as heart disease, diabetes, infectious diseases, and tuberculosis, have made it possible for some patients under therapy to proceed further in pregnancy than formerly. However, it is likely that the major part of the problem of premature birth—unattended by maternal complication in about 60 percent of the cases—is specific in nature and lies in the basic mechanisms of the smooth muscle cell and its metabolism as well as its neurologic and endocrinologic control.

The obstetrician must acquaint those entrusted with newborn care with any antecedent obstetric factors which may conceivably lead to intracranial injury through anoxia or trauma. The ultimate prognosis for the infant during the ensuing days, months, and years may in large measure depend upon the effectiveness of management during the critical minutes following birth.

Public health agencies should assist private organizations in providing clinic facilities for the prolonged followup of infants who responded poorly at birth or who were born under circumstances likely to terminate in remote sequelae.

More Knowledge

The *seventh factor* in planning for prevention of perinatal casualties is the continued acquisition of knowledge. Fully one-third of all deaths in the perinatal period are unexplainable through our current technics of study. A very large segment of the combined fetal and maternal mortality in the United States is due to functional disorders of the uterine muscular structure. Yet, when we look into these problems of uterine dysfunction, we find that we are ignorant of much of the basic pathophysiology involved. Even a basic understanding of maternal-fetal-oxygen relationships, and the precise effects upon the fetus, both immediate and remote, are fragmentary.

Broad areas of research must be encouraged in regard to levels of human reproduction and comparative physiology. Application of the knowledge gained to the betterment of perinatal welfare will inevitably follow. But the problem must be solved ultimately through the coordinated activities of multidisciplinary groups.

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REACHING DELINQUENTS THROUGH COTTAGE COMMITTEES

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THE OFFICES of the clinical personnel at the Boys Industrial School in Topeka, Kans., are strangely deserted between the hours of 9 and 11 a.m., 5 days a week. This is the time set aside for the cottage committee meetings in the various cottages. Every day the social workers, psychologists, and psychiatrists leave their offices to go to their assigned cottages for the meetings. Similarly, the chaplain, the educational and vocational coordinators, the directors of recreation and cottage life, the clinical director, and the superintendent attend these meetings, going from cottage to cottage according to a plan or a request for consultation. A teacher having difficulty with a certain boy may attend the meeting at his cottage to work on the problem with the committee, and occasionally some of the county social workers come in to help make plans for a boy to return to the community.

The Boys Industrial School is a State institution for boys who come into conflict with the law while under the age of 16. The present population of 170 boys ranging in age from 10 to 17 live in four dormitory-type cottages accommodating 30 to 60 and in two small cottages accommodating 9 and 15. There is also an orientation cottage where new boys live during a 3-week diagnostic period.

The cottage committee system was conceived in desperation after a number of years of trying to establish an effective treatment program on the part of professional staff. It is our effort to solve the perplexing question of how to get the clinical understanding to the people who live and work with the boys. It is also our attempt to answer the equally perplexing problem of how these people can share with their colleagues in offices the understanding they gain from their close association with the boys.

The interdisciplinary cottage committees meet for the sole purpose of achieving better understanding of the boys in their care and helping each to benefit from the treatment program planned especially for him. Upon entering BIS, a boy is told that his cottage committee represents his "home base"—the people who will work most closely with him and who will know the most about him, to whom he may take his problems and his plans, his joys and disappointments, and who together will carefully and systematically evaluate his progress, discuss his goals, and eventually make plans for him to leave the school.

Committee Members

The basic cottage committee consists of the senior child-care worker (classified under State civil service as a "cottage parent"), the social worker, and either a psychologist or psychiatrist as the team coordinator. Each person has a role to play in the total work to be done.

The role of the child-care worker is to represent management. He is concerned not only about individual boys but with providing the total group of boys in his care with good child care and an adequate group-living experience. He must strike a delicate balance in meeting the needs of a particular boy without allowing this to interfere with the total welfare of the group. He must provide a well-structured, clearly defined, balanced, educative, and supportive environment for the boys. He invariably becomes an important identification figure for the boys in his care.

The social worker is the liaison between the boy, his home, and the community. He is the authority in the committee when questions concerning family relationships, community pressures, the advisability of a pass or parole are discussed. He carries responsibility for clearing with the appropriate authorities all legal requirements and rights involved in passes, paroles, and related matters. While he is working with the cottage committee to help get the boy ready to return to his home he is also working with the family and the community to ready them to receive the boy.

The team coordinator has responsibility for leading the others in interpreting each boy's treatment needs and goals. He points out the psychological dynamics in the boy's behavior. He puts together the information given by the child-care worker, the social worker, the academic and vocational teachers, the therapist, the chaplain, the recreation leader, and the athletic coach to make a meaningful picture of what is going on within the boy. If it seems impossible to understand the boy as a total functioning being, the coordinator has responsibility for searching for the missing key. He also carrier responsibility for the boys' clinical treatment as well as responsibility for the effectiveness of the committee's work as a team.

No one discipline is more or less important than the others in the committee's total functioning, for they are interdependent. Each member, trained in his own particular discipline, understands best a particular facet of the boy and strives with the others to understand him as a total functioning being.

Since the cottage committee represented an entirely different way of working from what the staff was used to, we had much to learn and many problems to solve as we went along. From the beginning the coordinators have met in a weekly seminar with the clinical director to discuss problems. The seminar has been enlarged from time to time, to include all the basic committee members as the need arose. The meetings have been helpful to an understanding of the process, although sometimes painful.

For example, we did not anticipate the intensity of the relationship which would develop between the boys and the cottage committee and so were unprepared to deal with our feelings. Specifically this means that the boys tended to react to us both as a group and individually as they had reacted to the important figures in their lives. As they directed these old feelings toward us we were caught in the trap of reacting as if the feelings were meant for us personally. This was even more pronounced with the boys in psychotherapy and it soon became apparent that the therapist and the cottage committee must work closely together.

Team Relationship

To build an effective team relationship is no easy task. The barometer which tells if this relationship is as it should be is complicated, sensitive, and accurate. It is the boys themselves. We have learned over and over again that when a specific cottage of boys is restless—quarreling, fighting, strong-arming, running away—to look first at ourselves and then at our committee relationships. As soon as we begin to untangle our feelings, get the lines of communications straight, and perhaps redelineate our roles, the cottage settles down. In reacting to our uncertainty and instability as a committee, the boys act out their conflicts just as they have reacted to the instabilities, conflicts, and weakness in their own families.

Thus it is not only necessary to redelineate our roles for ourselves, but it is important that the boys understand these roles. A common denominator of juvenile delinquents is an uncanny facility for figuring out social situations, even though they cannot understand them. They learn this in order to manipulate for their own gains. To prevent them from trying to manipulate the cottage committee it is essential they be given an understanding of the roles within it.

There must be a basic trust and respect between the committee members, both as persons and as responsible representatives of their disciplines if a working relationship is to be developed. If the child-care worker views the committee members as spies he will not be effective as a team member. On the other hand, the coordinator who sees his role as "boss" or the "authority," or the social worker who delves into management, is also ineffective as a team member. One cannot force a working relationship; it is developed painstakingly, piece by piece as the individuals work together on a common goal.

In addition to trust in each other among the cottage committee members there must be mutual trust between cottage committee members and the boys with whom they are working. This is extremely difficult to achieve, as another common denominator in delinquents is their reluctance to trust anyone, least of all authority figures—a projection onto all adults of their hostile feelings towards the significant adults in their lives. Sometimes we are not able to reach a boy because we cannot gain his confidence.

The basic committee is enlarged from time to time to deal with specific problems, especially with other members of the child-care staff—housemother and day and night supervisors—who can contribute significantly to an understanding of the individual boys. For example, the night supervisor often has most important information concerning the boys' sleeping habits—whether they have nightmares, or walk or talk in their sleep. Similarly the housemothers often have intimate knowledge of what is troubling a boy, since many boys, held back from going to the male supervisors because of their conflicts with men, go to the housemothers with their problems. Sometimes the key which unlocks the understanding of a particular boy is held by the coach, the auto mechanics teacher, the librarian, the school janitor, or some other person with whom the boy has been able to develop a relationship.

The institution's division heads attend the committee meetings on a rotating basis or by appointment when they feel the need. Or a boy scheduled for what he feels will be a difficult cottage meeting, may ask his psychotherapist, the chaplain, or someone with whom he has a supportive relationship, to attend.

Ways of Working

The cottage committee system was inaugurated in September 1954, primarily to give support to the child-care workers, of whom the impossible was being expected. They were supposed to get enough from the diagnostic clinical staff conferences to be able to treat each boy in their care according to his needs and the clinical recommendations. Consequently, they generally felt defensive and were apt to view other staff members who came into the cottages as spies. The problems dealt with were the chronic ones, which were numerous.

At first the committees worked mainly on crises. It took some time for us to realize that this was a way of avoiding a realistic look at the problems of working together. As we understood this better, we were able to establish a substantial way of working together as we dealt with crises. Then, surprisingly enough, the crises began to diminish, and we could begin to think about a planned method of working.

By now each cottage committee has developed its own way of working, which depends upon the age group of the boys concerned as well as upon the experience and predilection of the individual staff members. However, basic similarities exist in all procedures. For example, each cottage has one meeting a week attended by all cottage personnel. This serves as a clearinghouse for problems of working together to provide a consistent, therapeutic cottage milieu.

A boy at the Kansas Boys Industrial School takes a problem individually to a meeting of his cottage committee, whose members (from left to right) are: senior child care worker, social worker, cottage mother, clinical psychologist.

At this weekly meeting problems of management are discussed, the boys are reviewed from the standpoint of changes, behavior, or problems presented, and recommendations are made as to passes, paroles, or changes in treatment plans. Clinical information in regard to new boys is presented and goals for them agreed upon.

The committee also meets with all the boys in the cottage together at least once a month and in some cottages every week. These assemblies have proved effective for working out inconsistencies in management, as well as cutting down on the possibilities for manipulations or playing one supervisor against another. Occasionally they are used for special events and thus are important as social, educative, and psychologically supportive experiences.

The committee devotes the remaining four meetings of the week to seeing boys individually and in groups.

Work With Individuals

When a boy attends the meeting alone it may be at his own or the committee's request. If a boy has been acting out his inner turmoil in aggressive behavior or getting bad reports of other kinds, the committee makes an appointment with him in an effort to find out what is troubling him. After the committee understands the message of these actions it is then in a position to help the boy work it out by helping him to recognize the real problem and often by steering him to the proper person—his therapist, social worker, teacher, coach, chaplain as the case may be—for further help. On the other hand, a boy may want help for some difficulty and may ask for a meeting. He may be having a problem in one of his classes, he may wish an adjustment in his program, he may be worried about things at home, he may want to discuss the possibilities of a pass or parole, and for a variety of reasons he may prefer to take his problem to the committee rather than to the individual staff member most closely concerned.

Sometimes a boy simply wants to ask the cottage committee where he stands. This usually happens when he becomes acutely aware of anxiety. He may ask the committee members if they think he is "crazy," announce that he is having a "nervous breakdown," or simply say he doesn't feel right.

While these problems may eventually need to be worked out in therapy if a boy has a therapist, the cottage committee by definition deals with the day-by-day problems as they occur. So many times a "nervous breakdown is a bid to talk about something else. For example, Donald, a partially sighted boy who denied his handicap and refused to try to be anything other than a fully sighted boy, has his "nervous breakdown" to let the committee know how difficult it was for him and that he was ready to accept help in regard to this problem.

Four boys have a group session with their cottage committee, consisting, in this instance, of (from left to right) chaplain, cottage mother, senior child care worker, relief child care worker, and clinical psychologist.

The most unusual cottage meeting I have experienced was the one at which a boy used a requested appointment to tell the committee how badly his father needed help, saying that he wished the father could get the kind of help he was getting at the boy's school. This meeting occurred after long months of individual help in the committee, during which the boy had struggled with his intense resentment and hatred toward his father. The same boy once told the committee during another requested appointment how much the religious activities at the school meant to him and said "Chapel always makes me feel so gay inside."

Work With Groups

An emphasis upon seeing the boys in groups has developed for both practical and psychological reasons. These boys are at an age at which boys naturally gravitate into groups.

The committees have done considerable experimentation with methods for group appointments. In group selection some cottage committees simply divide their roll by four, while other cottage committees divide their boys according to plateaus of adjustment, the top group consisting of those who are almost ready for parole and the bottom group consisting of the most difficult boys. Two main methods of group selection have been tried in the cottage for older boys. The first plan was based on Eissler's classification of psychiatric disorders into alloplastic (the acting out) and autoplastic (the holding in), with two intermediate groups.[1] These four groups attended the committee meetings on a rotating basis, so that each group was seen once a month. New boys were placed in these groups as soon as they had made their initial adjustment.

A chance remark overheard in the gymnasium one day caused the committee of this cottage to take a serious look at its group formation and working plans. One boy told another that his cottage committee worked very hard with them for 2 or 3 months when they were new, then forgot about them for 6 months, then pulled them out and worked hard with them for the rest of the time they were at BIS. This remark pinpointed for the cottage committee the vague feelings of dissatisfaction its members had had in regard to its work with groups. The committee then began to see all the boys every week. It decided upon a less technical criteria for forming the groups, mainly because its diagnostic tools were not fine enough to differentiate, and secondly because the "holding in" groups were difficult. The committee also found the boys tended to be more comfortable with boys who were new when they were. Therefore, groups were formed as a part of the natural process of intake—as soon as there were 10 new boys they became a group, having a 30-minute group meeting (sometimes more but never less) with their cottage committee each week as long as they remained at the school.

The cottage meetings for groups are reality oriented and not an attempt at group psychotherapy although the boys experience them as therapeutic and supportive. The purpose is to deal in a concrete, matter-of-fact manner with the everyday problems of the boy's life in the cottage. The boys are told not only that the committee needs to know them but that they need to know the committee. They accept this quite well although their ability to use the group, of course, varies with their individual makeup and the group's composition.

The content of discussion with a new group usually follows a pattern. The boys are told what to expect from the cottage committee and what is expected of them; their feelings and fears about living in a cottage with 40 boys are explicitly recognized.

The boys bring their gripes to the meetings, they suggest ideas, they complain about demands made upon them, or themselves make demands of the committee. Over and over they ask, "How will the committee know when we are ready to go home?" They talk of ways of getting along and holding their own. They have an uncanny aptitude for pointing out inconsistencies.

Behind the boys' complaints are two main questions: (1) Are you strong enough to protect us? and (2) Do you really care about us? Eventually the boys are able to express positive as well as negative feelings, usually when they are becoming strong enough to talk about going home. An important topic in the older boys' group is growing up and taking responsibility.

Continuing Evaluation

The multidisciplinary approach of the cottage committee system allows for continuous evaluation of the boy as a total functioning being. It is carried on informally as the daily log is read, as boys are seen, as special reports are read, as privileges and passes are granted. It also proceeds on a formal basis, each boy being evaluated at least every 3 months in the larger cottages and more often in the smaller cottages.

The formal evaluation is based on progress reports from those responsible for various parts of the boy's program, an interview with the boy, and a tying together of progress with the goals of treatment and criteria of change outlined at the first clinical staff conference. At these meetings recommendations are made for passes, parole, discharge, or further treatment.

The way a boy uses his cottage committee is largely up to him. One boy may choose to act out his conflicts with the committee; another may get strength and support from the cottage committee to work out his conflicts elsewhere. Once he has chosen, the committee is willing to go along with him.

For example, Robert, who had a well-balanced program consisting of library, community living, instrumental music, algebra, welding, varsity sports, and group psychotherapy had begun to show marked general improvement, with more control of impulses and more appropriate affect. He began to experience some meaningful relationships with men, but his conflict with women were causing him a great deal of trouble.

He talked bitterly of "female supervisors." He openly showed his anger to the woman psychologist on his cottage committee, complaining that he could not understand her because she used such big words. He deliberately cut her off, addressing his remarks either to the social worker or the child-care worker.

One day in his group meeting he suddenly looked very surprised and shouted to the psychologist, "I heard what you said!" There followed many meetings in which he kept driving at her, each time seeming to find something. Finally he was able to relate his feeling toward the psychologist to women in general and thus to his hurt and anger because his mother had deserted him. He gained the strength and support for this insight from his therapist, but chose to act out the problem in his cottage committee, using the psychologist as a transference figure.

Don, on the other hand, reversed this procedure. He acted out his conflict over his father with the printing instructor. As the separation process began, the conflict became more pronounced. The therapist and the cottage committee working together helped the printing instructor understand the problem so that he would keep on working with the boy.

This instance illustrates the interdependence between disciplines. The cottage committee would have been lost without the help of the therapist, and the print shop would have been unable to tolerate the boy's behavior if the instructor had not understood its meaning.

Relation to Therapist

What is the relationship of the cottage committee to the therapist in connection with boys in psychotherapy?

In the cottage for older boys three-fourths of the boys are in group psychotherapy. At first we thought that these groups would not need to be seen by the committee as frequently as others since they would be seeing their therapists weekly. However, it became even more essential for the committee to see them weekly in order to keep its reality structure clearly defined and let the boys experience the cottage committee as protective and supportive. As the psychological pressure rises within the boys and they become concerned with control of impulses which they do not yet understand, they find support through actions of the committee which seem to say: "We understand, we are in charge, we can protect you."

The therapist also finds support in being able to talk with the cottage committee and learn how the boy is getting along in his day-to-day experiences. The cottage supervisors too find support in being able to understand, when a group of boys become disturbed and restless, that this may be related to the therapeutic process and that they are needed more than ever to provide the boys with the reassurance of a protective milieu.

The cottage committee has become the hub around which the treatment services operate. As such, it has pulled them together. Also, it has minimized the most perplexing of all institutional problems—intercommunication. It has become the clearinghouse for information of all kinds concerning the boys, not only receiving information but also sending it out with interpretation of its meaning in regard to the boy's progress and treatment goals.

The cottage committee system has been an important factor in stabilizing the school's entire treatment program by making it possible to reach the boys sooner and to take them further in the treatment process, both by providing a stable therapeutic milieu and by paving the way for more individualized treatment.

The cottage committee has become an important instrument for inservice training of all staff and particularly of child-care workers, giving them support and clinical understanding as well as the gratification of being an indispensable part of the team.

As far as the staff is concerned, we no longer are conscious of a chasm between professionally trained and other institutional workers. There is no longer the feeling that some staff members are on the "front lines" while others remain comfortably in their offices. We are a team of dedicated people, of various disciplines, working together for a common goal and getting gratification as we feel ourselves grow personally and professionally. Our focus is on the boy—his needs, his welfare, his potentialities for becoming a firstrate, productive person and citizen. We offer a multidisciplinary approach to the multidetermined problem of delinquency.

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[1] Eissler, K. R.: Some problems of delinquency. *In* Searchlights on delinquency. International Universities Press, New York, 1949.

We need only remember that underneath the outer mask of an adult size and dignity, behind the official position, rank or prestige of the grown-up man or woman, there is always a little boy or a little girl, still living over the hurts, the injustices, the unhappiness of a forgotten childhood.

Lawrence K. Frank

Some suggestions from a public health administrator on . . .

A PUBLIC HEALTH AGENCY'S ROLE IN ADOPTION

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ADOPTION, in the United States, in 1958, is an extraordinarily complicated field. Is it one in which public health workers have a part to play? My own views of the answer are colored by the experience of the Kansas State Board of Health with foster care to children. This experience has been neither extensive nor profound, and most of it has been peripheral to adoption, but it has had some unique features.

The State board of health in Kansas licenses all types of foster care facilities for children and all private child placing agencies under a law passed through the efforts of the maternal and child health division in 1919. This was originally a solo performance, but in 1951 the law was amended to require specific studies and approvals by the child welfare division of the State department of social welfare before any license was issued. The amendment established a community of interest and a working relationship between the two agencies that is rare in this country. The program involves at present nearly a thousand applications for license yearly, of which something over a hundred are for homes in which children have been placed for adoption by a private agency but have not yet been legally adopted.

We have had, therefore, for many years a window through which to observe adoption practice, and a certain amount of authority and responsibility for improving what we have seen. What we have seen may be typical for the Great Plains States only, but as nearly as we can make out it is not grossly atypical of adoption throughout the country; the children, the parents, the agencies, and the problems are much the same everywhere. The only entirely atypical thing is for a health department to have an observation post because it is generally taken for granted that public health has no concern with adoption at all. This assumption would be considered valid by most professional people, since most of the physicians, nurses, and administrators in public health work have nothing whatsoever to do with adoption from the beginning of a fiscal year to its close.

There are, however, a number of opportunities for public health workers to engage cooperatively with others in this field, if one looks for them. Public health agencies register illegitimate births and write new birth certificates when children are adopted and perhaps there is useful information to be gleaned from all these records. Public health agencies are expert in arranging good medical supervision during pregnancy for the indigent or uneducated mother, and social agencies have difficulties in providing such care for the unmarried mothers with whom they work. The increasing public health interest in perinatal mortality and morbidity could have some bearing on the quality of the children placed in adoptive homes.

Public health workers are, or should be, relatively skillful in statistical analysis and evaluation, something in which child welfare work is not yet strong. They often engage in a multidisciplinary approach to social problems and have enough self-confidence to engage in it freely, which might make them useful

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Based on a paper presented at the 1958 meeting of the American Public Health Association.

in adoption practice where social work, the law, medicine, and psychology should work together smoothly. The public health field has been well acquainted with the uses of publicity for a long period of time, while social work only recently has become convinced of its importance, especially in the matter of adoptions.

In public administration, health agencies are older and perhaps more experience than their counterparts in the field of social work. The public health agency is a little cynical about human nature. Skimmed milk will persistently masquerade as cream, and have a high bacterial content, unless standards are established and enforced and frequent inspections are made. This sort of attitude could be useful in adoption work, where the important element of protection to children strictly requires good laws and good law enforcement.

The benefits of an interest in adoption on the part of public health workers would not all flow in one direction. The public health field can learn a great deal about children and the conditions of childhood from child welfare practice, a knowledge which can be used to the advantage of any maternal and child health program. Involvement with adoption practice specifically can lead to a better understanding of certain significant public health problems, such as abortions (both natural and criminal); the incidence and etiology of infertility; morbidity and mortality among illegitimate children; natural mother-child relationships and the development of motherliness; the consequences of maternal deprivation; and the early identification and alleviation of handicapping conditions in children.

The Picture Today

Let us take a brief look at the adoption picture before looking further at ways in which public health agencies might become involved. Professionally speaking, placement of a child for adoption is the intimate and special sphere of the child welfare worker. It lies at one end of a whole spectrum of services to children deprived of parental care and is the logical objective for the child who has no family because his parents are dead, or have deserted him, or have relinquished him because they cannot provide proper care, or because parental rights have been severed by court order.

The social worker's job is to find the right permanent home for a particular child, a home where in all probability he will find love and security and support until he is an adult. The rules for accomplishing this are largely empiric. Until recently there have been, to my knowledge, no properly controlled studies of adoptive placement which would identify the important variables and afford some firm basis for determining practice. Child placement is in fact an art, although considerable research to give it a scientific foundation is underway.

In the case of independently arranged adoptions, almost anybody may substitute for the social worker and her agency setting. Many people feel confident that they can arrange good adoptive placements,[1] and this natural confidence is apparently enhanced by postgraduate training in law, medicine, and theology. The independent placers are usually ignorant of the empiric rules, and rarely make enough placements to be able to work out rules of their own. They think in terms of finding a good child for a particular family rather than a good family for a particular child.

Placement of the child in a family home is a prelude to the very important legal procedure of adoption. The law varies from State to State, but it usually requires that a petition to adopt be filed in probate court by the prospective parents, and that it be accompanied by a consent to the adoption signed by someone who has a right to give consent—either the natural parents or the appropriate social agency. In most States an investigation must be made by a social agency if the child is not related to the petitioners. However, even if investigation shows that the placement is by no means a satisfactory one, as is often the case in independent arrangements, the petition is usually granted anyhow. The courts are unwilling or unable to take the responsibility of removing a child from a home in which he has lived for some period of time.

The Children

The adoption picture is further complicated by the fact that there are about five distinctly different categories of children needing adoption, each with its individual problems and each overlapping the other to some extent.

Category A is composed of healthy, well formed, white babies who are usually illegitimate. The demand for such babies greatly exceeds the supply. The social agency has no trouble in finding homes for such children, but great difficulty in pacifying the would-be parents for whom no child is available. A large percentage of the children in this category are placed by individuals and not by agencies.

Category B, at the other extreme, consists of children for whom it is just plain hard to find adoptive homes. These are children with significant mental or physical handicaps, children with major personality disturbances, and children from minority racial groups or mixed racial backgrounds. As short a time as 10 years ago most of such "hard to place" children probably would not have been considered for placement at all. In the last decade social agencies have learned that good homes can be found for them if the responsible agency will exert enough honest effort. Since the effort is always expensive and the price of failure is responsibility for expensive, long-term foster care, there is a tendency to consign these children to placement agencies that are tax-supported.

Category C children are those midway between A and B, without pronounced handicaps but not so young or so white or so attractive as the A babies. These require for a good placement enough work and skill to make the task professionally rewarding. A few of the younger ones are placed independently, but as a general rule these are agency children.

Category D consists of foreign-born children, the majority from European countries. For the most part, they are young and white and healthy, though this is certainly not the case with the children of mixed Negro and Korean racial backgrounds that have been arriving in this country recently. National and international social agencies have made increasingly successful efforts to exercise supervision over intercountry adoptions, but nevertheless many of the usual protections for the child are lacking. Some of these children are adopted abroad by proxy and may suddenly appear in this country without the knowledge of any responsible social agency.

Category E, consisting of stepchildren and children adopted by relatives other than parents, is the largest, the least dramatic, and certainly the most neglected from the standpoint of social control. Nearly half the children adopted in any given year fall into this group. The word "stepchild" has a bitter meaning in the English language, and our society has taken no real action to change its semantic implications. These children receive little supervision in some States and none at all in others. They are sometimes considered the responsibility of the courts that take divorce petitions—which are courts that are seldom provided with social workers.

Is it proper to call any of these children socially disadvantaged? There is not, I think, any yes or no answer to this question. From one aspect, it might always be considered better to be adopted than to be without a family; from another, a bad placement is complete disaster for the child. The question of disadvantage is plainly bound up with the alternatives that are available.

A parentless child is disadvantaged if a good adoptive home could be found for him but is not.

An adopted child is usually disadvantaged by a placement arranged independently if the available services of a qualified agency have been intentionally bypassed or overlooked.

A child placed in adoption by an agency is disadvantaged if the agency's practices are poor or outdated.

If public health agencies can favorably affect any of these disadvantaged children, and particularly if they can help them in ways that other agencies cannot, then public health has a real responsibility. In actual fact, many of these children are being touched by the public health programs for all children, but much more could be done if there was some focusing of the effort.

A Public Health Program

A public health "adoption program" might consist of three main elements: (1) activities designed to make more parentless children available for adoption; (2) activities designed to reduce the frequency of independent placements; and (3) activities designed to improve agency adoptions.

1. Making children available. There are many ways public health agencies might make more children available for adoption. They can help to report illegitimate births promptly and routinely to appropriate welfare authorities, so that no illegitimate child will be overlooked. Routine visiting by the public health nurse might be required for illegitimate babies who leave the hospital with their mothers, a procedure that would keep some infants alive to be adopted at a later day, and at the least would insure that the child does not disappear from sight altogether. Public health nurses and physicians see a good many young children suffering from gross physical neglect as one aspect of gross parental neglect, or bearing visible marks of mistreatment. Such cases should be reported to the authorities. A child's own family is hard to replace, but some parents are hopeless and their children may be better off if placed for adoption.

Residential institutions, especially in the Southwest, contain many young children who are adoptable, but growing less so with each passing month. Public health agencies may not have direct authority over such facilities, but they can exert powerful moral suasion. In Kansas we have had some success in shaking these children out of the institutions, chiefly by pressing for qualified child welfare services as a necessary part of their organizational structure. When a public health agency informs an institution of its need for social work services, it may be more convincing than when the public welfare agency gives the same advice.

Many children with major physical handicaps could be adopted were it not for the high cost of long-term medical and hospital care. If tax-supported care is available to a child who remains a State ward, but is not available or not freely available if the child is adopted into a family, the public health agency has some obvious responsibilities for straightening things out. Similarly, public health knowledge and skills can be used in preparing handicapped children for adoption at the earliest age possible.

2. Reducing independent adoptions. In efforts to reduce the frequency of independent adoption, educating the public and the professionals is important. In Kansas the State board of health supplies physicians with pamphlets for use with their childless patients to stress the advantages of social agency adoptions. It participates in interprofessional meetings on adoption such as one held by the State medical society's committee on maternal welfare with the heads of the leading child placing agencies in the State. Following this meeting an editorial appeared in the medical society's journal deprecating the arrangement of adoptions by physicians.

It is helpful to have a straight story to tell. The impression is sometimes given that out of every three independent adoptions, one baby turns out to be defective and another is forcibly reclaimed by the natural mother. These are rare occurrences. Agency placements are always to be preferred (1) because they favor the interests of the child, who is helpless, over those of the would-be parents, and (2) because they bring professional knowledge and skill to bear on a crucial event in the child's life. They are not perfect, but they are safer.

Giving birth to an illegitimate baby under social agency auspices might be made less formidable. If, as actually happened in Kansas a few years ago, an unmarried mother is presented with a choice between, on the one hand, spending her pregnancy in a sunny apartment, receiving medical care by a specialist as a private physician, and having first-class private hospital care, and, on the other hand, living in an unpleasant boarding house, receiving medical care in a chilly public clinic, and being delivered in a hospital for indigents, she can be excused for choosing the superior facilities even though these are offered by a lawyer operating independently rather than by a social agency. Moreover, a well cared for, well nourished, comfortable pregnancy is likely to result in a better baby. Because social agencies rarely have enough money properly to underwrite a pregnancy, public health skills can be of real help. In some States, notably Indiana and Connecticut, effective cooperative programs have been developed.[2]

Public health agencies usually have excellent relationships with the hospitals in which most illegitimate babies are born. Hospitals are made uneasy by independent adoptions initiated within their walls and usually welcome advice on how to proceed most ethically with their unmarried maternity patients. For these patients, receiving a written statement of what agency services are available may be more useful than just being handed a copy of "Infant Care" alone, with the compliments of the health department.

The enormous demand for nice babies, which is the basic cause of independent adoptions, could be reduced if more of the childless couples who want children could produce their own. In Kansas, we were able to give agencies assistance in establishing factual criteria for sterility by furnishing outlines for an examination and a list of qualified physicians, and occasionally giving direct consultation. Since nobody really knows how many couples are sterile, or whether sterility is increasing, the subject suggests itself as valuable for study by public health agencies. Better fertility studies will also reduce the incidence of pregnancy after adoption of a child, an event which is not catastrophic but which tends to make things more difficult for the adopted child.

3. Improving agency practices. In attempting to improve social agency practices, public health agencies must of course tread rather carefully. Perhaps the most effective approach would be to offer skill in designing and carrying out carefully controlled cooperative studies of adoptive placements. Such projects might well be underwritten through money available for mental health research, as badly placed children are likely to have a high incidence of identifiable psychological difficulties.

The sum of our knowledge of children is increasing rapidly, and health agencies may be aware of new concepts long before they filter down into social work. In Kansas the State health department was pressing for early placement of newborns into adoptive families and doubting the reliability of "infant testing" for predictive purposes for many years before these ideas became a part of accepted child welfare thinking. At present we are trying to convince our colleagues in child welfare that one foster mother in a temporary boarding home cannot care for the needs of more than two infants. We have every confidence that time will prove us right.

One of the real barriers to early placement of infants is the widespread supposition that many illegitimate babies who appear normal at birth will prove later to be more or less defective. Most pediatricians would probably favor an opposite theory, that even the ones who appear defective at birth are likely to be quite normal, but pediatricians do not generally have an extensive experience with illegitimate babies as a class. There may be a basis of fact in these misgivings, or there may not be, but no one will be sure until there are comprehensive studies comparing children born within wedlock with those born without. (One reason that we do not have such studies is the secrecy surrounding illegitimacy. In Kansas, one risks a jail sentence if he attempts to inspect birth certificates of illegitimate children.)

Birth certificates can help improve adoption practices by providing information needed to assess the child's hereditary potential. Unmarried parents may disappear from sight, leaving the information on the birth certificate as the only information available for determining the child's hereditary background and the circumstances of his birth. In Kansas the division of vital statistics has spent a good deal of effort obtaining completion of certificates that have been filed with the father's name listed as "unknown." We have only rarely found an unmarried mother actually so promiscuous as to preclude proper completion of the certificate.

Health departments routinely make certain services available to babies and parents who stand to profit by them. It seems fairly certain that adopted children are not apt to fare as well as those born into a family in the usual way. If visits by a public health nurse when a baby first comes home do promote good adjustments, if the "Pierre the Pelican" letters used by many States do help parents understand children, if well-child conferences do indeed bring about better mental and physical health, they should be made available to adopted children. As it stands, the adopted are frequently overlooked because the machinery of the health department gets confused in the absence of specific channels of communication between social agencies, courts, and local health departments. There is no good reason why such channels should not be established.

These possible activities, drawn from the experience of just one State, suggest that the public health field has its contributions to make to adoption practice, even though they are relatively small. With adoptions taking place at the rate of 90,000 a year and the trend ever upward, no health department could be criticized for devoting some special time and attention to this group of children in special need.

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[1] Thornhill, Margaret A.: Unprotected adoptions. *Children*, September–October 1955.

[2] Curtis, Hester B.; deRongé, Alberta: Medical and social care for unmarried mothers. *Children*, September–October 1957.

In human affairs, there are not only the right sides of questions and the wrong sides, there are human dilemmas. Situations arise where, it seems, whichever course is taken great loss or injustice will result. In such cases good human management tries to find solutions which will secure the maximum of gain with the minimum of loss. Imagination and creativeness sometimes have a part to play, as well as good intent.

"The Story of Community Service," Arthur E. Morgan in Community Comments, *February 1958.*

YOUTH PARTICIPATION IN COMMUNITY AFFAIRS

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IN A DEMOCRATIC SOCIETY active citizen participation in all phases of community living is of major importance. Opportunity for young people to participate in community affairs is essential to the realization of this goal. It provides the training ground for the development of mature, resourceful adults capable of participating in a dynamic society.

Spurred to a realization of this relationship by the Midcentury White House Conference on Children and Youth in 1950 and by the increasingly obvious necessity of reinvigorating the institutions of democracy presented by subsequent world events, youth-serving agencies, schools, and civic groups have for the past decade been exploring ways in which young people might take more meaningful responsibility, not only for their own immediate interest but also in areas of concern to the total community. In fact, even before that youth-pervaded conference, during the years of World War II, an awareness of young people's potential for managing their own affairs and working with adults in community activities seemed to be on an upswing. Teen canteens developed throughout the country, with youth and adults functioning together in program planning and policy making. Community youth councils were organized in many places so that a widely representative group of young people could express their opinions, raise questions, and work on special projects of community-wide importance.

Yet the questions are still frequently raised: "Can teenagers really participate with adults?" And, if so, "How?"

Five years ago Y-Teens of the YWCA in 27 cities—6 in the East, 12 in the Midwest, 7 in the South, and 2 in the West—made a simple survey of approximately 3,000 other teenagers, on the question: "Do you think that teenagers have privileges and responsibilities as citizens even though we do not vote?" The interviews took place during leisure hours in neighborhood centers, youth canteens, and "hangouts" among the young people who happened to be there. In one instance a civics teacher became interested and had the survey made in several civics classes.

The overwhelming reply of these 13-to-16-year-olds was "Yes." Many of them cited the fact that the Bill of Rights offers nonvoting citizens the same protection as it offers voters. In regard to their comments the *New York Times* reported: "The youngsters named freedom of speech and worship, educational and labor opportunities, and the use of public facilities such as libraries among their privileges. They predicted that a more liberal attitude by adults toward teenagers would bring them more privileges and responsibilities as citizens." [1]

The questionnaire used in the survey asked further: "What have you done or are you now doing to make your community a better place in which to live?" Leaving spaces for checking *Am doing now* or *Have done*, it listed the following activities:

Take part in traffic-safety projects.

Work in Community Chest and other drives.

Cooperate with other groups in working for better schools (promote bond issues, teacher-education recruiting, academic freedom).

Work as an aid in hospitals.

Serve as aids to group leaders to help with activities for small children in community centers.

Volunteer for other school and community projects (give examples).

Hold a part-time job and function reliably as a worker.

Study the structure and function of government—local, State, and National—and work to enlighten others.

Study to understand the work of the United Nations and work to enlighten others.

Participate with adults in YWCA and community activities.

Take part in international projects (name).

Work with communications media to publicize the worthwhile things teenagers are doing.

The replies showed that in one city all 400 teenagers interviewed checked that they are now working on or had worked on at least one of the community projects listed. In another city the 200 teenagers interviewed checked at least two activities which they had been or were presently engaged in. More than 50 percent of all those interviewed in the survey were now working on or had previously worked on one or more of the following activities: (1) traffic-safety projects; (2) community drives; (3) part-time jobs; (4) government study projects.

Approximately 50 percent were now or had previously taken part in: (1) U.N. study projects; (2) school and community projects other than those listed; (3) community activities, working side by side with adults.

Less than 50 percent were now or had previously worked as: (1) hospital aids; (2) aids to group leaders in work with small children; (3) participants in international friendship and exchange projects; (4) participants in efforts to publicize through the communications media the worthwhile things teenagers are doing.

Enlarging the Scope

As the foregoing shows, most community activities for youth have been of a service nature. Such activities should not be belittled for they help young people to explore vocational avenues, pursue new interests, discover the importance of understanding persons of many racial, cultural, and economic backgrounds, and find the meaning of citizenship. It is important that this traditional approach be retained.

Young people today, however, because of the extended use of the community as a laboratory in education, increased opportunities to participate in conferences, work camps, and international exchange, and the ready store of information available through radio, television, newspapers, and magazines, can effectively enlarge their field of community participation. They need help from capable adults to do so.

Movement in this direction was taken in April of 1958, when 60 teenage leaders met in New York City in a consultation called by the Committee on Youth Services of the National Social Welfare Assembly to discuss youth in community affairs. The young people were asked as consultants to help the committee obtain a view of young people's opinions about ways in which youth is presently participating or might be encouraged to participate in community affairs. In planning the consultation the committee, composed of adult representatives of national youth-serving organizations, sought to create an atmosphere in which the young consultants would be able to express their opinions and feelings freely, leaving the adults to listen, observe, and to serve as advisers on request.

As they talked to each other these young people came to the conclusion that "only a small percentage of youth are participating in community affairs," and they wanted to find out why. They also exhibited considerable concern about adult attitudes toward youth, the problem of understanding themselves, and how to achieve self-respect and status.[2]

Their report records their belief that: "Young people like us *are* interested in community affairs, but we represent only about 10 to 15 percent of the youth of our age. . . . . . . Another large group, probably 75 percent of all teenagers, could be interested in programs which include community affairs, but 'they need a little push.' . . . Another 10 percent would definitely not be interested. . . . . . . But even these *could* be reached 'because after all everybody has *some* interest and you can appeal to young people through whatever interest they have.' "[2]

The few skeptics, such as the young man who asked, "why does everybody have to be interested in community affairs—adults aren't?" were far outnumbered by the young persons who expressed the conviction that it was "both appropriate and important for youth to work with others to improve community life."[2]

There were, however, those who registered reservations about the extent to which young people should participate in community activities, pointing out that in these years schooling is most important and nothing should interfere with it.

Thus through directly consulting with young people themselves youth-serving agencies have been trying to see the strengths and weaknesses in their present programs, as well as new opportunities for enabling young people to take their place *now* in community life.

Contributions of Youth

Giving youth a place in community life is not entirely a matter of training young people for adult responsibilities. Today's adults have much to gain from the process. Says Max Wolff, associate professor of sociology at New York University, "In periods of crisis affecting the fundamentals of society the vision of youth must be blended with the knowledge of experienced elders to create the new basis for tomorrow's social organization. Such a critical period exists today in the American community." [3]

It is well then to take a look at life throughout the United States to see what are the major forces affecting the well-being of communities and then to ask, Can youth help? This does not mean to ignore those needs related to youth per se, such as the ever-present need for additional recreational facilities, but rather to accept the fact that any major public issue in one way or another not only has some bearing upon the degree to which young people can grow to their fullest stature as citizens but may itself benefit from the freshness and frankness of the young.

Among the many problems facing our country today are a number in which young people have a direct stake. In regard to public-school integration, they are the ones who have firsthand experience. Their awareness, insights, and hopes in relation to their own abilities might also be taken into account as plans are developed for improving educational opportunities and school curricula and facilities.

Our Nation's difficulties with other countries might even be eased somewhat if the natural openness of youth and their ability and willingness to see through outward differences to the inner similarities in people could be fostered. A 17-year-old girl, who spent a summer in Germany on a scholarship saw this when she said: "In 2, 3, or 4 years we'll be the airline hostesses, military personnel, trainees for diplomatic service, and tourists. If we could have more opportunities now to get to know youth in other countries who will also be moving into these areas of responsibility, we'd save a lot of time in achieving a wholesome working relationship, which is so essential to real international cooperation and good will."

Recently a group of 17 Y-Teens and 8 adults working on plans for the 1959 National Y-Teen Conference on Youth's Role in National and World Affairs emphasized the importance of young people's finding ways to express the goals of our Nation to the world in other than material aid. They pointed out that urging young people to build their skills in all the arts and languages could make a vital contribution in "presenting to the world the real face of America."

Some guidelines for analyzing how young people might appropriately contribute to any particular project might be found in estimating the degree of ability and knowledge required for various elements of the task; the quality and nature of experience necessary to bring reality to the approach; the abilities and skills needed to accomplish the goal; and the interrelationships that might enhance the work in process and bring the added benefits of good human relations and understanding at its completion.

Some Projects

Young people and adults are already working together in a number of projects to find ways of involving youth in local, national, and world concerns. Several national youth-serving organizations have advisory councils of youth constituents, which meet with national planning groups to evaluate program and participate in the development of new program. The National Council of Churches of Christ in the United States of America included young people as fully accredited delegates in a recent "high level" conference on the church and world order. Y-Teens are now recognized as full members of the YWCA, with opportunity to attend triennial national conventions as delegates. The Michigan Youth Advisory Council, composed entirely of young people, has initiated a program that bears on the well-being of the State as a whole, including projects to promote summer employment for youth; traffic safety; and improvement of the labor, educational, and recreational conditions of migrants.

The Wisconsin Youth Committee for Community Youth Participation, open to all young people through a county-district-State structure, is officially recognized as the channel for the expression of young people's opinions on public affairs. With adult consultation provided by the State department of public welfare the committee attempts to draw youth into community affairs by providing clearing-house services and by holding an annual State conference for the exchange of ideas and experience. Its State committee, chosen by the young people in district elections, works closely with the Wisconsin

Committee on Children and Youth, a body of adults and young people appointed by the Governor, which has among its responsibilities the promotion of local youth councils. To help such councils inject vitality into adult-youth partnership, the youth members of the Governor's committee have prepared the pamphlet "Youth Participation on the March," [4] containing pointers for successful youth participation with adults in planning.

For several years young people in California have participated in the planning and deliberations of the Governor's youth conferences. The 1958 Conference on Youth Participation in Community Affairs offered an opportunity to discuss a wide range of interests including the family, the school, the church, jobs for youth, the motor age, delinquency prevention, community affairs, accomplishments of youth, and youth fitness.[5] The report of the conference indicates that youth and adults entered freely into discussion and that there seemed to be acceptance of the need for partnership on the part of each. Reported one work group: "Youth and adults have something to share with each other. Neither group has all the answers. The important thing is developing good relationships and moving together with mutual trust and respect."

Principles for Success

As groups in towns and cities work to achieve more extensive and vital youth participation in community affairs, it is well to consider some of the factors that may help and those that may hinder their efforts. These might be identified by a consideration of the following questions:

1. What experiences in family living, school, church, and community groups will help young people become ready and willing to take part in the real issues of living?

2. As young people are helped to participate in community affairs, what are their motivations and expectations?

3. If young people seem unwilling to take responsibility in various phases of community life, what is the basis for their reluctance? What can be done to help them discover their own potential for participating in community life in a way that will have meaning for themselves and be of benefit to the community?

4. If adults invite youth to participate, what are the adult motivations and expectations?

5. As youth participates, how much should adults expect of them?

The role of the adult—singly and as an identifiable segment of the community—is an important key in the discovery, release, and utilization of the skills and potential of youth. It is important for those promoting adult-youth partnership to understand and accept some of the natural breaches between adolescents and adults, and find ways for them to work together in spite of these. The natural idealism and enthusiasm of youth along with the fact that most young minds are as yet uncluttered by the fears and prejudices that beset adults can bring an effective enthusiasm, not usually supplied by adults alone, to the tackling of many important tasks. Adults working to bring youth into meaningful participation in community affairs need an understanding of adolescent behavior, hopes, and aspirations, as well as an understanding and acceptance of themselves and their own strengths and limitations. They also need to have a knowledge of the elements at work in the community that enhance or hinder effective relationship, and to possess skill in helping people to work together in groups.

In searching for methods for promoting youth participation some groups may turn first to the formal organization of a youth council. With on-

A San Francisco high school girl leads a nursery school singing group to the accompaniment of the teacher's guitar. Work with children is a popular activity among teenage girls who volunteer to serve their communities.

going staff and adequate adult leadership, such a group can be an effective channel for young people's efforts, relating their concerns to those of the community at large. However, creation of a council does not have to be the first and only step toward increased youth participation in community life. A conscious effort ought to be made by both adult and youth leaders to examine the activities in which young people are already involved in relation to their effectiveness and satisfaction for youth and for the community. In the process new avenues of interest may be opened as unmet needs become apparent.

After such a review of the current scene young people and adults together might make a careful selection of some immediate goals as well as a long-term plan for including youth regularly in all phases of community effort and concern. Then a group of young people and adults, representatives of various youth and community groups, might consider when, how, and at what points young people of various ages—junior or senior high school or college age—can and should be given the opportunity to participate in specific efforts.

In its pamphlet, previously mentioned,[4] the Wisconsin Youth Committee cites several basic principles for successful youth participation in program planning:

In predominately adult groups there must be enough youth to lend support to each other.

No youth group can function satisfactorily without mature adult support and guidance.

When youth are sitting in with adults, extra time must be taken to keep the youth informed.

Adjustments must be made in meeting times, places, and methods when youth are being brought into adult programs—but also the inverse is true.

Whether youth or adults, special effort must be made to stay in contact with the people represented.

Youth must assume responsibility for showing adults what is desired of them. Sometimes, the nonparticipation of adults is a conscious effort not to take over.

Time must be allowed for both planning and evaluation if youth are going to learn by participating.

"Adults need to pave the way for youth participation, but the real effectiveness will come when the individual youth accepts his privilege and assumes his responsibilities," the pamphlet predicts.[4]

A look at communities generally does not show the vital quality of youth participation that is needed to pour new strength into our democratic way of life. Too often youth participates only in a phase of experience which has very little chance of penetrating or changing the total community. However, the fact that in the past few years young people have been taking more and more responsibility for various community drives and are serving as volunteers in many community services may indicate next steps in participation. As young people ask to help with community projects, adults must be willing to accept their offer and provide the guidance that will enable them to take responsibility meaningfully. A scheme for making ways of participating in community affairs available for all young people would provide widespread training so that the leadership necessary for dealing with the myriad problems of our society would be encouraged to emerge.

"Participation in the democratic sense is a complicated art;" writes Max Wolff, "only a few are born masters, but many, most of the people, can learn it. The best method of learning is active and continuing practice. Three conditions must be fulfilled to induce individuals to try themselves out as participants. They must be sure that: they are really welcome by the coparticipants; they are asked to participate because of their qualifications as coworkers; their participation will be a meaningful contribution to the goal of the cooperative activity."[3]

With proper encouragement, youth can be a positive force for bringing about the changes for good that a dynamic society must constantly seek.

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[1] *New York Times*, Monday, April 19, 1954.

[2] National Social Welfare Assembly, Committee on Youth Services, New York: Report of consultation on youth in community affairs. 1958.

[3] Wolff, Max: Youth must participate. *YWCA Magazine*, February 1959.

[4] Wisconsin Committee on Children and Youth, Madison, Wis.: Youth participation on the march. March 1958.

[5] Department of the Youth Authority, Sacramento, Calif.: Report of Governor's conference on youth participation in community affairs. February 1958.

What questions have been engaging the attention of research workers during the past ten years?

A DECADE OF RESEARCH CONCERNING CHILDERN

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WHAT CAN BE DONE for retarded children? Does parent personality play a part in schizophrenia? How can children get better health services? Can delinquency be predicted and, thereby, prevented? Can adoptive homes be found for the older children, handicapped children, Negro children? What should be done for the gifted child? Do tranquilizing drugs have a place in the treatment of children? How can the teenager become a safe driver? What are the effects on children of racial desegration in the schools? What factors influence physical growth? How do children react to hospitalization and surgery?

All these questions and many more are being asked today by persons concerned with services for children. Many are being answered through slow, careful study. And, as each question is answered, investigators move on to the next question. Seemingly a slow process this, but a look at 10 years of research reported to the Children's Bureau Clearinghouse for Research in Child Life indicates that headway has been made toward solving some problems. Some questions have been so well answered that the problem and its solution have become history; other investigations have proved futile and been abandoned.

The staff of the Clearinghouse has often wondered if a close inspection of reported research would indicate any trends, startling developments, or a picture of step by step but undramatic accomplishment. The Clearinghouse has now been in existence for 10 years, collecting information on on-going studies concerning children and reporting on them in its publication, *Research Relating to Children.* It seems an appropriate time to stop and look at the several thousand studies reported since 1948.

The studies currently included within the scope of the Clearinghouse and hence those considered in this article are all in the following areas: child growth and development—physical, mental, emotional; personality—"normal" and disturbed; school life—achievement and adjustment; services for children—health and welfare; and the social and cultural factors that affect child life.

This survey of 4,415 studies does not include consideration of purely medical studies, master's theses, reviews of published materials, or administrative studies of such matters as school construction, local service needs, and the like. Some such studies were included in early issues of *Research Relating to Children,* but since the coverage was always incomplete, any generalizations drawn from them would be invalid. The Clearinghouse no longer attempts to collect such reports but limits its coverage to the areas which can reasonably be covered and which, it is hoped, will be of general interest to the various "consumers" in all fields concerned with the development of children.

For convenience, the studies have been grouped into those reported in three periods: 1949–51—1,601 studies; 1952–55—1,243 studies; 1956–58—1,571 studies. They are dated according to the year in which they were reported, although some of them have continued over several years.

Now, what has been happening in the years since 1948?

Mental Retardation

The most obvious, and perhaps most gratifying, trend to be noted is the increase in research on mental retardation. Nearly 4 times as many studies concerned in some way with mental retardation were reported to the Clearinghouse in the years 1956–58 as in the years 1948–51—151 in contrast to 42. Much of this increase is due to the large Federal sums appropriated for research—mostly disbursed through Office of Education contracts with State departments of education and with universities. The National Institute of Mental Health also continues to spend a considerable amount supporting research in this field. But the Federal legislation which made the funds available was a reflection of the increased interest on the part of the public—especially parents, educators, and professional health and welfare personnel who saw the need of more knowledge about this problem.[1]

Not only has the amount of research increased, but the direction has changed. Of the 42 studies reported in the earlier years, 10 were concerned with the effects of glutamic acid on raising the I.Q. Not a single study on glutamic acid has been reported to the Clearinghouse since mid-1950. Since the early research effort found no evidence of the treatment's effectiveness, investigators have turned their attention to other, perhaps more promising, paths. Increasing attention is being given to causes of retardation, with emphasis on infections in pregnancy, birth injury, and most recently to metabolic disorders, such as phenylketonuria, which are associated with retardation. There is also much current experimentation with the effects of tranquilizing drugs on mental development, on academic achievement, and on the behavior of some types of mentally retarded children.

One would almost think that the tranquilizers are now being administered to everyone for everything. They are being studied in relation to their effects on perception, on stuttering, on physiological functioning, on enuresis, on fantasy, on learning, on reading, and on the motor behavior of cerebral palsied children. Much of value may come out of this work in psychopharmacology. The results will determine whether research along these lines will continue at such an enthusiastic level over the coming years.

With such a large amount of support for research in mental retardation coming from an educational source, it is not surprising that an abundant interest is being shown in education for the retarded. Close attention is being given to how and how much such children learn. And there is an increasing inclination to delve into the possibility that rather severely retarded children can be educated and that children formerly considered hopeless are trainable in a variety of self-help ways. For these children and for their parents this research effort is providing ever more hope.

Education

At the other end of the mental scale, reporting on research on the gifted has increased from 5 studies in the first few years of the Clearinghouse (1949–51) to 30 in recent years (1956–58). The volume of these studies is still not large but will no doubt increase as the country more and more demands the best brains to carry forward the Nation's business. Sputnik I played its part in stimulating research on gifted children, but even before October 1957 educators had begun to consider how to identify the talented, how best to educate them, and how to hold them through high school and send them on to and through college.

The picture of research on the educational process—omitting special education for the gifted and the retarded—has not changed greatly, although research in special education for all kinds of pupils has increased, not only for those children handicapped by inadequate vision or hearing or other physical defects, but also for the socio-economically handicapped such as migrant and non-English-speaking children.

After the Supreme Court of the United States handed down its decision that racial segregation in public schools is unconstitutional, it was to be expected that there would be research on the effects of desegregation in the schools. One study was reported within the year. Nine additional studies have followed. However, the psychologist Stuart Cook believes that much more research can and should be done while the laboratory set-up is unique and well-nigh perfect, with communities at all stages of progress.[2] The need is not only in the psychological field, but equally so in sociology and education.

Child Development

Work on aspects of physical growth has declined somewhat in amount and continues without noticeable change in direction. Research concerned with the effects of nutrition on growth appears to have declined, but this may represent poor coverage by the Clearinghouse rather than actual fact. Work on mental growth—aside from the gifted and retarded—has about doubled in volume, with most of the increase going to studies of learning: How does it take place? How can it be increased? What factors of environment or personality retard it?

Interest in special aspects of personality development in the child, such as oedipal development, oral habits, insecurity, moral character, has somewhat declined. On the other hand, there appears to be increased interest in interaction within the family, particularly between parent and child, leading to emotional disturbance. Disturbances in personality have been receiving increased attention over the years. Twice as many studies have been reported in recent years on schizophrenia alone. More and more concern is being shown with treatment—evaluating the effects of residential treatment, experimenting with drugs and with day care treatment.

In another area of great interest these days—juvenile delinquency—there has been no change in the number of projects reported but some change in the type of research investigation. There is a sustained interest in the possibility of predicting delinquency. There seems to be less concern with socioeconomic conditions as causes of delinquency—for example, low income, poor housing, ethnic background. There has also been a trend away from study of the effects of individual therapy toward a look at the effects of groupwork, the effects of street corner workers, and, most recently, the role of courts, probation and parole officers, and detention workers.

Services

In nearly all areas of research on services for various categories of children, there seems to be a trend toward sharpened focus and more sophistication. How many children with what kinds of problems need what types of services? There is less dependence on merely surveying the numbers of children on parole, children receiving aid to dependent children, children being seen in well-child conferences. We find researchers looking for the answers to such questions as: Can a parole officer do a better job if his caseload is cut down to a half, or a third? Why do some families continue to receive public assistance while others drop off the rolls? Why do parents not keep their appointments at a well-child conference? There continues to be a certain amount of head counting, of course, because there is much that is still not known: What is the actual incidence of illegitimacy? How many children need protective services? How many are receiving them? Through what avenues? What are the gaps in services?

The Clearinghouse coverage of research in the area of health services has never been complete. Therefore, it is hard to judge trends in this broad field. Two changes in respect to health services are, however, quite dramatic. In 1949 and 1950, 12 studies were reported on tuberculin testing in health departments and in schools. In 1958 only two such studies were reported—reflecting progress toward the solution of this public health problem—with new research directed not toward how good is the test, but how can it be applied to all children. Another public health measure that has shown a definite pattern is water fluoridation—beginning with seven studies reported in 1949, five in 1952, five in 1955, tapering off to one in 1958—again evidence that an answer has been found in regard to the effects of fluoridation and it is now up to the practitioners to use the knowledge gained.

In welfare services no obvious changes have occurred. This is probably due, perhaps inevitably, to the fact that studies in the social service field are directed essentially toward recommendations for social action and toward improvement of services. There was and is a fair amount of research interest in foster family care, in availability of child welfare services, in characteristics of families receiving aid to dependent children. For a while research activity seemed to have lessened in such areas as adoption and day care of children, but our "grapevine" suggests that investigators are returning to the problem. Knowledge about day care is of increasing urgency in view of the fact that in March 1958 there were 7,494,000 married women in the labor force with children under 18 years of age—an increase of 62 percent over 1950. Much effort continues to go into surveys of needs for services—for unmarried mothers, children in their own homes, youth groups. There appears to be more current interest in personnel needs: What makes a good houseparent? How can an institution hold on to its staff? What is the role of case aids in easing the workload of professional workers?

The general picture of research activity in the welfare field is not impressive in size, so far as reports to the Clearinghouse show. The number of studies reported continues to be rather small. This is probably due to the fact that it is difficult to obtain good coverage outside of formal research centers and universities. Many welfare agencies undertake short-term projects from time to time, which are usually completed before the Clearinghouse hears about them. Therefore, the Clearinghouse is not in a good position to comment on either the quantity or kinds of social service research.

Suggestions for Future

Any review of research leads naturally into the temptation to suggest possibilities for future research. It is probably not appropriate that the Clearinghouse staff should venture very far in this direction, except in areas which are of particular concern to the Children's Bureau.

So from discussions with Children's Bureau specialists the following possibilities emerge:

Mental Retardation. While research effort in mental retardation has increased so dramatically, there is still much to be done. The current emphasis on special education and other aspects of schooling is certainly overdue and should provide some of the answers that parents and educators need. But answers in other areas are also needed.

We know too little even yet about the seemingly simple matter of measuring intellectual ability. The tests now in use measure only a narrow range of abilities and are not always dependable in the little they do measure, being affected by cultural differences, test anxiety, and other factors. We also need to know more about factors which may contribute to retardation—socio-economic differences that affect adequate functioning, psychoses which may cause behavior suggestive of intellectual limitation, individual differences in temperament that may affect functioning and adjustment. Much might be done through longitudinal studies of growth and development which would help to guide parents and teachers of retarded children, if an adequate theoretical base could be laid. It would also help those who work with retarded children and their parents to know more about how such children affect other members of their families, how parental attitudes affect these children, and how community attitudes toward them affect the total family constellation.

Delinquency. In delinquency research the drift away from investigating socio-economic causes may be a mistake. Journalists, legislators, and a dozen kinds of individuals often claim to know the specific causes of delinquency. It seems important to obtain more solid information than we now have about whether maternal employment, dropping out of school, and the passing of the woodshed are really factors in causing delinquency. It seems necessary to know causes in order to prescribe better treatment. It is certainly necessary to validate the techniques for delinquency prediction so that special efforts to help will be directed to those and only those "predelinquents" who need it.

Much time and money and enthusiasm go into "reaching out" services and baseball equipment and curfew laws. It would seem essential to find out which approach works with what kinds of children. We also need to find out all we can about the types of persons having contact with children who affect them for better or worse—policemen, teachers, social workers, doctors and nurses, even shopkeepers—with consideration of how they might be better prepared for the roles they must play.

Health. States and local health departments are often waiting upon increased knowledge of casual factors and incidence of disease or disability so that they can institute preventive programs and provide better services for all children. What are the effects of radiation from X-rays in a shoe store or a dentist's office? What other sources of radiation are affecting children? Does the usual school physical examination really uncover serious health problems? If not, what constitutes a good examination, good enough to be useful and cheap and easy enough to be practical? Are the programs in maternal and child health and crippled children's services actually raising the health status of our children? How available and how good are medical services for children in foster homes, rural children, children in the slums?

Welfare Services. In the broad area of welfare services there is much we need to know. To date, there has not been the amount of systematic, controlled research in this field that has been carried out in other areas. Welfare services continue, as they must, on the basis of common sense or tradition. But more validated answers are needed at all levels.

Accurate "base" statistics are still needed. For example, until we know how many children need special types of care, we have no realistic base for planning. Are they rural children, slum children, or all children?

To improve social agency practice, we need to have more rigidly designed and better replicated studies to test the effectiveness of current practice. On what bases do caseworkers decide whether a child should be placed in a foster home or in a group care facility, or remain in his own home? Can these be made more objective? How successful are agency adoptive placements as contrasted to independent adoptive placements? What are the identifiable characteristics of children and adoptive parents who have achieved a successful adoption? What are the presenting problems of adopted children in psychiatric clinics? What of unmarried mothers? Who are they? Why are they? What needs to be done for them?

Are neglectful parents different from other parents—quantitatively, qualitatively? What does change of environment mean for children—moving from the country to the city and from the city to the suburbs? What do they gain and lose?

Another level at which answers are needed is administration. Does the form of agency organization affect the quality of services? What is the effect of trained and untrained personnel? How does turnover of staff affect services? Why is there turnover? Is it greater or less than in other service fields? While attempts are being made to answer some of these questions about staff turnover [see page 154], there is still much to learn.

Are there principles of administrative and fiscal management which can be applied to welfare agency administration? How can the gap between service people and budget people be bridged? Between service people and the public?

Parent Education. Cutting across all of these areas is the sprawling, often ill-defined field known as parent education. What, in 1959, is parent education? Who is doing it? Who should be doing it? Can parent educators be trained as such or is parent education a set of special skills to be added onto professional training in another field. Does parent education promote parental anxiety or parental competence?

Are expectant parents ready for the type of help a nurse might give them in preparation for family living? What cultural factors affect the readiness of parents of delinquent children to accept what the social worker can offer? When can parents of a mentally retarded child accept the necessary counseling from a doctor? How can we evaluate present efforts to educate parents?

These are some of the kinds of questions that practitioners need to have answered. When they and others like them have been answered, we can confidently predict that there will be twice as many asked.

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[1] Garrison, Mortimer, Jr.: Research trends in mental deficiency. *Children*, January–February 1959.

[2] Cook, Stuart: Desegregation: a psychological analysis. *American Psychologist*, January 1957.

. . . We fall into serious error when we define modern science as pure objectivity, totally untouched by intuition or recognition of the human equation. Such a concept is fantasy, and it is fictional. When it is applied in the field of human welfare it results in quick generalizations which set limits on the potential of human beings. Institutions are crowded with people who have been declared hopeless on the basis of a so-called scientific judgment. Can we as social workers surrender all responsibility for struggling with what others have called impossible? For the missionary scientist, the heart has been known to do the leading. The secrets of success are in the heart as well as the mind.

Robert H. MacRae in his presidential address to the 1959 annual forum of the National Conference on Social Welfare.

An essay-review . . .

ASSESSING EFFORTS TO PREVENT DELINQUENCY

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THE MARCH 1959 issue of *The Annals*, "Prevention of Juvenile Delinquency," describes 14 action programs mainly of a demonstration or experimental project type.[1] All these programs are geared to preventing and controlling delinquent behavior. But very few of these reports define exactly what it is that they are trying to prevent. Lacking a definite target, they have difficulty in assessing how close they are to or how far they are off their mark.

It is assumed that the projects selected for presentation and assembled in this volume include the better and more scientific, hence more notable, research endeavors. Conspicuously absent in this series of papers is any reference to recent research efforts to prevent delinquent behavior through early identification of children who are vulnerable, exposed, or susceptible to the development of norm-violating behavior. Of course it may be that these preventive measures have already been publicized beyond their scientific limits, so that their omission may not be so much an oversight as a matter of quality control.

When the action programs and experimental studies reported in this volume are stacked against earlier accounts of similar ventures as compiled by the Gluecks in *Preventing Crimes: A Symposium* (1936)[2] or against the more recent and more critical evaluation of selected delinquency prevention programs by Witmer and Tufts in *The Effectiveness of Delinquency Prevention Programs* (1954),[3] the reader can sense how far research workers and program planners have come. Improvements can be seen in the research design, in the theoretical conceptualization to be found in some reports, but mostly in the sophisticated style of research writing with its self-conscious awareness of the usual limitations in experimental design involving the classical problems of adequate controls and of evaluation. What is still lacking in almost all reports, as the editor points out in her foreword, is precision and validity in the evaluation processes.

True, as Dr. Witmer makes clear, not all the projects reported on in the volume were selected on the basis of having included the undertaking of scientific evaluation. Some were purely action programs of a creative nature, which the reporters frankly assess on the basis of impressions unfounded in any evaluative methodology. Still the missing keys to scientific determination of the value of any program or community effort to prevent delinquent behavior are precision and validity. However, this volume gives testimony that most (but not all) project reporters have learned to write with scientific restraint and to acknowledge openly the technical limitations of their studies.

The Evaluation Barrier

If these studies collectively point to any one conclusion, it is that the program planners and research workers have not yet succeeded in breaking the evaluation barrier to enable us to say that certain planned experience, when carefully engineered, really can prevent delinquent conduct. The reporters of some of the studies, such as the Chicago Area Project, tend to evaluate their efforts on the basis of the meticulousness in carrying out the program activities according to the concepts of the theory on which the program was built. In this appraisal, if the rationale and assumptions are valid and if the action program is managed and executed in accordance with the stated hypotheses, the tendency is to pronounce the study effective. But this, as the reporter himself explicitly recognizes, is far from scientific validity.

In other reports, "The Effectiveness of a Boys' Club in Reducing Delinquency," by Roscoe C. Brown and Dan W. Dodson, and "The Effects of a Revised School Program on Potential Delinquents," by Paul Hoover Bowman, the authors, though noting that definitive answers are precluded by the limitations of their methods, strain to assess effect by utilizing peripheral data. Still other project reports such as "The All-Day Neighborhood Schools," by Adele Franklin, and "Delinquency Prevention Through Revitalized Parent-Child Relations," by Ruth S. Tefferteller, describe their results through the use of anecdotal or selected case study data. These reports find values in their programs through a process more subjective than objective.

Another overall impression gained from reading through this series of action programs and research effort is the clear focus on the community, the neighborhood, the gang, and the family as the locus of much of the problem of rule-violating behavior. This is in sharp contrast to earlier tendencies to lean heavily in the direction of the child guidance clinic and therapeutic counseling. Instead of focusing on the delinquent or predelinquent (the latter is never defined, and in one report is renamed a semi-delinquent) in a one-to-one relationship, almost all projects work through the milieu—whether this be the family, school, boys' club, work camp, or street corner. This represents a promising change and a much needed shift in the direction of the cultural and subcultural forces that frequently generate and reinforce delinquent conduct.

Some High Spots

A number of the reports—particularly the 25-year assessment of the Chicago Area Project by Solomon Kobrin, the street corner group work in the Boston Delinquency Project by Walter B. Miller, and the group therapy program with the Navy and Marine offenders within a closed community by J. Douglas Grant and Marguerite Q. Grant—show a high order of theoretical conceptualization as a base on which to set the action program. These directors provide clear rationales for their studies. In other reports, however, the reader must infer from the nature of the activities described the basic definitions and hypotheses on which the program rests. These need to be stated explicitly.

There is a refreshing contrast to "all good and all effective" reporting in the brief but factual summary by Antoinette Fried of the difficulties and failures, as well as some good results, met in the work camp program with potential delinquents in Newark, N.J. Rare indeed in these days of self-reporting and subjective writing is a careful documentation of defeat. But important lessons can be drawn even when few delinquents are saved, if observations are made scientifically and if interpretations are carefully drawn.

Some research studies apparently never close. Joan and William McCord report another extension of the much analyzed Cambridge-Somerville Youth Study. Delayed effect of the personal help given to the experimental group as measured against the unaided controls has been further appraised through a careful check of the subsequent records of 253 treated boys and 253 matched controls. The investigators reaffirm previous findings that the Cambridge-Somerville Youth Study failed to prevent law-violating behavior.

One satisfactory attempt at evaluation in this series can be found in the report of the laboratory-like experiment conducted by the Grants in the treatment of nonconformists in the Navy through group dynamics. In this project the most precise research design and appraisal methodology were conceived and carried out within the confines of a rigidly controlled environment of a correctional institution operated by the armed services. Such controls are not so readily established within an open community.

Whence comes the direction and the financial support for the prevention programs described in this volume? Judging from these reports, the private foundations and the National Institute of Mental Health are godfather and godmother to most of the research being undertaken. Many of the research and demonstration programs described are directed by persons connected with universities or private organizations and agencies. Conspicuously absent are reports of research planned by municipal and State-supported institutions and agencies such as youth service boards, juvenile courts, and child welfare agencies. It may well be that persons working in these tax-supported units are busy coping with the delinquency problem and have little time or inclination to fuss with prevention or experimentation, or their job descriptions may not include research activity in regard to prevention.

Steps Toward Improvement

All the reports in this volume argue for better evaluation. Improvements in scientific appraisal will come only after the research workers define more precisely what constitutes a predelinquent (semi-delinquent or potential delinquent), after they spell out exactly what they are trying to prevent, and after they explicitly state the constructs within the rationale of their studies. Several of the reports indicate that a good start in one or two of those directions has already been made. For example, Kobrin, Miller, the Grants, and Eva Rosenfeld have set down their hypotheses, definitions, and assumptions.

If the first step of definition can be cleared, the next job will be to determine the most appropriate technique for gathering data most relevant to the specified goals. The third step will involve the construction or refinement of appropriate and promising measures for gathering significant data. The last step will demand a check for validity and reliability of the data-gathering technique prior to its use. In short, the building of valid and reliable evaluation tools and techniques, assuming we know our specific goals and targets, still represents the major task to be faced. This may call for a special research study in itself. It is at this point that research effort and monies need to be invested.

With one notable exception, the projects in this volume represent short-term, even abortive, efforts at delinquency prevention. Some of them should be extended and tested on a long-term basis. Many of these programs can be and should be tested by replication. As they now stand, many of them add something to the growing fund of concepts concerning prevention and control of delinquent behavior.

No one report in this volume—nor even all the reports together—will answer the current demand for sure methods of preventing delinquency through communitywide or statewide programs. However, in the midst of the wasteland of opinion and talk, these reports represent a refreshing oasis of experience, though much of it remains still to be tested and verified.

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[1] Witmer, Helen L. (issue editor): Prevention of juvenile delinquency. *The Annals*, March 1959. (American Academy of Political and Social Science, Philadelphia.) $2 paper bound; $3 cloth bound. 213 pp.

[2] Glueck, Sheldon and Eleanor (editors): Preventing crime; a symposium. McGraw-Hill Book Co., New York, 1936.

[3] Witmer, Helen L.; Tufts, Edith: The effectiveness of delinquency prevention programs. U.S. Department of Health, Education, and Welfare. Children's Bureau Publication No. 350. 1954.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

HOW MUCH AFFECTION? 20 minutes; sound; black and white; purchase.

Shows how feeling between boys and girls develops an intensity that is sometimes difficult for them to control; suggests how young people can be helped to deal with this problem.

Audience: High-school and junior-college classes; mixed groups of teenagers, teachers, and parents.

Produced by: Crawley Films, 1958.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N.Y.

WHEN SHOULD I MARRY? (Marriage and Family Living Series.) 19 minutes; sound; black and white; purchase.

Presents some of the questions young couples need to consider before deciding whether they are ready for marriage.

Audience: High-school students.

Produced by: Crawley Films, 1958.

Distributed by: Medical Arts Productions, 414 Mason Street, San Francisco.

MAKING A DECISION IN THE FAMILY. 8 minutes; sound; black and white; purchase.

Raises the question—as the basis for audience discussion—of whether a father and mother were right in insisting that a teenage daughter should break a coveted date in order to attend a cousin's birthday party.

Audience: High-school students; parent-teacher and church groups.

Produced by: National Film Board of Canada, 1958.

Distributed by: McGraw-Hill Book Co., Text-Film Department, 330 West 42d Street, New York 36, N.Y.

HELP FOR YOUNG HEARTS. 14½ minutes; sound; black and white; purchase or rent.

Emphasizes the importance of prevocational and vocational counseling for children with damaged hearts.

Audience: Parents of children who have heart disease; professional groups that work with such children.

Produced by: Potomac Films for American Heart Association, 1958.

Distributed by: American Heart Association Film Library, 267 West 25th Street, New York 1, N.Y.

CONGENITAL HEART DEFECTS. 9½ minutes; sound; color; purchase or rent.

Explains the underlying physiology of five common congenital heart defects.

Audience: Staffs of crippled children's agencies; medical and nursing students; parents of children with congenital heart defects.

Produced by: Churchill-Wexler Films for American Heart Association, 1958.

Distributed by: American Heart Association Film Library, 267 West 25th Street, New York 1, N.Y.

BOOK NOTES

THE CHILD WITH A HANDICAP: a team approach to his care and guidance. Edited by Edgar E. Martmer. Charles C. Thomas, Springfield, Ill. 1959. 409 pp. $11.

This collection of papers, planned to help professional workers and parents to join with others in helping children with various handicaps, includes discussions of the place of various sources of help for the child and his parents, written by a pediatrician, a mother of a retarded child, a psychiatrist, a social worker, a teacher, a representative of an adoption agency, and a counselor in medical genetics. Other chapters are devoted to each of a number of types of handicapping conditions, including: amputations; cerebral palsy; congenital heart defect; convulsive disorders; diabetes; emotional disturbances; mongolism; progressive muscular dystrophy; nephrosis; poliomyelities; cystic fibrosis; rheumatic fever; and disorders of vision, speech, and hearing. The editor is the past president of the American Academy of Pediatrics.

DESEGREGATION—SOME PROPOSITIONS AND RESEARCH SUGGESTIONS. Edward A Suchman, John P. Dean, Robin M. Williams, Jr., with the assistance of Morris Rosenberg, Lois Dean, and Robert Johnson. Anti-Defamation League of B'nai B'rith, New York. 1958. 128 pp. $2.

This book, according to the authors, is intended mainly as a stimulant to research and as a suggestive guide to action in racially desegrating the public schools in accordance with the Supreme Court decision of May 1954. The authors summarize present social science knowledge relating to school desegregation as a social process and suggest what that knowledge implies for the actual course of desegregation. They warn, however, that "only in combination with specific knowledge of a local community setting" should their suggestions be used as directives for action.

Part 1 of the book presents a number of general propositions about six aspects of the American social scene and their implications for the desegregation process: social stratification; power in the community; public opinion and propaganda; interaction and communication; prejudice and personality; and the minority community. Part 2 evaluates a number of approaches to research in the light of their past and present success in the field of intergroup relations and suggests examples of needed research and research methods.

The authors are professors of sociology at Cornell University.

CURRENT CONCEPTS OF POSITIVE MENTAL HEALTH. Marie Jahoda. Joint Commission on Mental Illness and Health, Monograph Series No. 1. Basic Books, New York. 1958. 136 pp. $2.75.

First in a series of monographs reporting a national mental health survey, this book, written by a psychologist, analyzes various assumptions as to what mental health is other than absence of mental illness. Among other criteria discussed are: attitudes toward self; self-actualization; integration of self-perception and growth; autonomy; perception of reality; and environmental mastery. Discussing the possibility of there being a diversity of types of mental health, the author urges that more research be carried out on specified mental health concepts and offers suggestions on methods for taking the next steps.

A concluding chapter, contributed by Dr. Walter E. Barton, presents the "Viewpoint of a Clinician" who works on the assumption that the "absence of health" and the "presence of illness" necessarily coincide.

REHABILITATION: a community challenge. W. Scott Allan. John Wiley & Sons, New York. 1958. 247 pp. $5.75.

A broad view of the services and objectives of a comprehensive program for rehabilitation of the handicapped is presented in this book, written by the chairman of the Rehabilitation Council. Addressed chiefly to persons concerned with community planning in this regard, it includes discussions of the tools of rehabilitation, the roles of the various members of the rehabilitation team and of the various types of facilities involved in rehabilitative efforts, legislative authority for rehabilitation programs, the costs and financing of rehabilitation, and planning at all levels from local to international.

Among various steps listed by the author as important in such planning are: weaving the pattern of rehabilitation into the practice of medicine; planning for adequate rehabilitation facilities; integrating public and private programs; recruiting and training personnel; improving legislation to include specific provision for rehabilitation; gearing insurance and health-plan programs toward rehabilitation; encouraging community acceptance of all the handicapped; maintaining flexibility of programs to meet changing disability needs.

DEVELOPMENTAL POTENTIAL OF PRESCHOOL CHILDREN: an evaluation of intellectual, sensory, and emotional functioning. Else Haeussermann. Grune & Stratton, New York. 1958. 285 pp. $8.75.

A method of demonstrating a neurologically handicapped child's possibilities for development is described in detail in this manual, written for psychologists, therapists, teachers, and others concerned with planning the education and training of children so handicapped.

Unlike a standard intelligence test, which measures children's abilities in comparison with the abilities of other children of the same age, the "educational evaluation," as described by the author, analyzes the child's functioning in relation to his own unique pattern of learning and provides results that can be used as a basis on which to plan his educational and training program. The evaluation is made through a structured interview between a handicapped child and a clinical psychologist, in which the psychologist works to motivate the child to reveal the level and quality of his comprehension.

The author is educational consultant in the division of pediatric psychiatry, Jewish Hospital, Brooklyn.

HERE AND THERE

Staff Turnover in Social Agencies

The Children's Bureau recently completed analysis of data on professional staff losses in child-welfare and family-service agencies during 1957. The study was carried on with the cooperation of the Child Welfare League of America and the Family Service Association of America. Participating agencies were the member agencies of these two organizations (except a few nonservice agencies) and the public child-welfare agencies in all States. Highlights of the findings:

1. During the study year, professional staff in the participating agencies averaged 10,328 employees (includes full-time staff only in the child-welfare agencies; full-time and a few part-time staff in the family-service agencies). Of this number, 2,876 employees, 28 percent of the total, left their jobs during the study year. For caseworkers, the average separation rate was 34 percent. Of the total separated, over 70 percent resigned; 9 percent went on educational leave.

2. Basic reasons for resignation of full-time staff (reported in confidential questionnaires by the employees themselves and, in separate questionnaires, by the agencies) have already been tabulated for the 1,600 resignees who were on duty in the participating agencies at the beginning of the study year. Among the five leading reasons reported by both agencies and employees, were: to accept the offer of a better job; moved from community; maternity; and inadequate salary. Agencies also ranked "demands of the home" among the five leading reasons; employees, "dissatisfaction with supervision."

3. The leading basic reasons for resignation reported by men were: to accept the offer of a better job; inadequate salary; and lack of advancement opportunity—accounting, alone or in combination with other reasons, for 70 percent of the resignations of men. Dissatisfaction with supervision, professional education, moved from community (not job-related), and dissatisfaction with program policies of the agency accounted for 19 percent.

4. The five leading basic reasons for resignation reported by women, accounting for two-thirds of their resignations, were: moved from community (21 percent); maternity (17 percent); to accept the offer of a better job (16 percent); dissatisfaction with supervision (11 percent); and demands of the home (9 percent).

5. Of all the 1,600 resignees, 39 percent resigned because of reasons having nothing to do with the job—marriage, maternity, moving, and demands of the home—reasons beyond agency control, once the employees in question have been recruited and hired. Practically all of these were women.

6. Women on the agencies' staffs at the beginning of the study year outnumbered men by nearly 5 to 1. Women 30 years of age or younger comprised over a fifth of total staff, more than a fourth of all caseworkers. Men of all age groups comprised 15 percent of the casework staff. Most of the men were married; most of the women, single. Of the men, about two-thirds had completed 2 or more years of graduate social work education; of the women, fewer than half. Men had a significantly higher resignation rate (total, 20 percent; caseworkers, 25 percent) than women (total, 17 percent; caseworkers, 20 percent).

7. Of all resignees, 12 percent reported that they did not intend to return to social work, or preferred other fields should they return to employment. About 22 percent were uncertain about returning to employment or to social work. The remaining 66 percent were already reemployed in, or reported definite intention to return to, social work.

8. Of the child-welfare resignees, slightly over a third reported that they were reemployed in, intended to return to, or preferred child-welfare work; of the family-service resignees, slightly over a fourth reported similar interest in family-service work. The remaining resignees expressed interest in fields other than, or uncertainty about, the field from which they had resigned.

There are significant differences when the three study fields (public child welfare, voluntary child welfare, and voluntary family service) are compared; also in findings for fully trained, partially trained, and untrained staff. These will be detailed in the full report, to be published by the Children's Bureau later this year.

—William B. Tollen

Conference on Mental Health

On April 10–11, the Committee on Preventive Psychiatry of the State University of Iowa held a Second Institute on Preventive Psychiatry, assisted by the Grant Foundation, the Iowa Mental Health Authority, and divisions of the Iowa State University, building on work done at the first institute 2 years ago.

The keynote speaker was M. Brewster Smith, professor of psychology, New York University, with the topic "Recent Contributions of Research to the Development of the Concept 'Creative Mental Health.'" He pointed out the strengths and weaknesses of three approaches being used: (1) analyzing the behavior of persons judged to be mentally sound; (2) using many criteria to derive indices of mental health from the study of large samples; (3) following the mainstream of research in personality development to find out how mental health values cluster and compete with other values "in the arena of personal and social choice."

There is little which is yet firm in mental health research, Professor Smith indicated, but a great deal of promise in a combination of these leads. The particular advantage of the third approach, he said, is the "out" it gives in trying to account for persons who by ordinary definitions are mentally healthy but socially destructive or who are extremely creative but mentally ill. "Mental health thus viewed," he concluded, "is complex and not easily schematized. . . . We will not always want to give it priority."

John W. Lovett Doust, M.D., associate professor of psychiatry, University of Toronto, reported research going on at his institution on the relationship between the very early physiological experiences of the fetus and predisposition to psychiatric disorders, particularly schizophrenia. Anoxia during gestation, he said, may result in morphological immaturities which account for later neurological and psychological deficits.

A study of the interrelationships between the social environment and health and their implications for the prevention of mental illness was reported by Lawrence E. Hinkle, Jr., M.D., of the New York Hospital, Cornell Medical Center. This research, he said, indicates so far that people, regardless of cultural and other environmental differences, fall into two groups on the basis of their general susceptibility to illness—the "well" and the "ill"—which are noticeably different in the way they perceive their lives.

In other papers Harold J. Berman, professor of law, Harvard University, compared Russian and American legal systems, and Ralph D. Rabinovitch, M.D., director of Hawthorn Center, Northville, Mich., reviewed studies on the genetic aspects of mental illness—both finding implications for prevention.

The conference discussions afforded opportunity for participants from many scientific disciplines to explore the interrelationships between two conceptions of mental health: prevention of mental illness and a positive creative human development.

—Muriel W. Brown

Health Studies

Analysis was recently completed of the data gathered in the first stage of the project being carried out jointly by the Children's Bureau and the National Office of Vital Statistics to learn something of the size and characteristics of the health problem presented by cystic fibrosis of the pancreas. (See CHILDREN, January–February 1959, p. 36.)

In the first stage of the study, carried out January 8–February 13, 1959, figures on patients with cystic fibrosis were requested from a sample consisting of 616 hospitals in continental United States—about 9 percent of the nonpsychiatric hospitals listed in hospital directories for 1958. All 296 of the hospitals approved for pediatric residency were included in the sample. The information collected covers each of the 6 years 1952–57, and includes: (1) number of patients with diagnosis of cystic fibrosis discharged from the hospital, including discharges due to death; (2) total number of discharges of such patients; (3) number of deaths of such patients in the hospital. More detailed information was received for the year 1957.

The survey indicates that from 1952 to 1957 the number of persons with a diagnosis of cystic fibrosis discharged from hospitals, including those who died, increased by 50 percent—from estimated totals of about 1,700 to about 2,500. About 98 percent of these patients were under 20 years of age. The estimated number of persons with a diagnosis of cystic fibrosis dying in hospitals increased by about 20 percent between 1952 and 1957—from about 300 to 360. The data also indicate an increase during the period in the total number of discharges, from an estimated 2,100 in 1952 to 3,200 in 1957.

According to the study directors, the increases in hospitalization on account of cystic fibrosis probably resulted in part from improved diagnostic procedures. They also point out that the fact that these increases occurred chiefly in hospitals other than those approved for pediatric residency suggests an increased awareness of the disease outside of the pediatric centers.

The numbers of persons with diagnosis of cystic fibrosis dying in hospitals ranged between 14 and 25 percent of those discharged during the 6 years. From another study, based on information obtained from a sampling of 1958 death certificates, the National Office of Vital Statistics found that in 1958 one-fourth of deaths attributed to cystic fibrosis occurred outside of hospitals.

As the joint project progresses, the survey data will be combined with other information to give an overall estimate of the frequency of cystic fibrosis in the general population.

The full report of the survey will appear in a coming issue of *Public Health Reports*, published by the Public Health Service, Department of Health, Education, and Welfare.

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Seeking a quick and inexpensive method of discovering heart abnormalities early in life, the Public Health Service is cooperating with the following Chicago groups in recording the heart sounds of 40,000 children in Chicago public elementary schools: the local heart association, the city boards of health and education, and the county medical society. Each heart-sound recording is listened to by at least two cardiologists, and the findings of each are checked against the other to obtain greater accuracy.

A followup screening physical examination is then performed by the cardiologists on children whose heart sounds are not normal. Children with examination results defined as positive for heart disease are then referred to a private physician or clinic for diagnosis and treatment.

Through the study, which will last 18 months, the participating agencies expect to find out what operational problems may be involved in mass screening programs for discovering heart defects. Epidemiological data will also be collected on children with previously undetected heart defects, which are located with the help of the heart-sound recorder.

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A pilot study of New York City teenagers who have contracted or been exposed to a venereal disease has been begun by the American Social Hygiene Association. The purpose of the study is to find some of the social factors leading to infection among persons under 20 years of age and to arrive at a means of control through effective case-finding techniques. The study, which will consider the social, economic, and cultural background of each teen-ager included, is being carried on in city venereal-disease clinics with the cooperation of the city health department.

Prenatal Care

Lack of prenatal care of mothers was associated with deaths of babies in the first month of life in a study of 1956 live-birth and death certificates made recently by the District of Columbia's Department of Public Health.

Among infants born alive of mothers who had had no prenatal care the neonatal mortality rate was 48.0 per 1,000 live births, more than twice the rate for all infants born alive in the District, which was 20.8. About one-fourth of all the neonatal deaths during the year occurred among the babies of women who had had no prenatal care. Among the babies who died in the first month of life whose mothers had had no prenatal care more than 80 percent were born prematurely—their birth weights were less than 2,501 grams.

In a study of some 5,800 live births occurring in the same year at the municipal hospital where about half the mothers had received some prenatal care and the rest none, it was again found that the neonatal mortality rate for babies of mothers who had received no prenatal care was more than twice as high as for the group that had received such care. The mothers in both groups were of similar economic status, since the hospital is used for obstetric care only by persons regarded as "medically indigent." The neonatal mortality rates for both groups were somewhat lower than the rates for the corresponding groups among all live births in the District.

White House Conference

A plan for the program structure of the 1960 White House Conference on Children and Youth was adopted by the executive committee of the President's national committee early in May

About 7,000 persons are expected to attend the Conference, which will open and close with plenary sessions. Every delegate will be assigned with some 30 other persons to one of about 200 work groups, each dealing with a defined subject.

The Conference will have daily "Theme Assemblies" of about 1,400 persons each, in which a number of work groups will gather together for a presentation related to the Conference theme. Work groups having closely related topics will then meet in forums of about 350 people to hear presentations of facts and issues related to the theme and to their specific subjects of concern.

At the final plenary session the delegates will hear reports on various subjects, prepared with the help of elected representatives from each work group, and reflecting both majority and minority opinions. These reports will become part of a published record of the Conference.

Plans for the White House Conference also call for the preparation of pre-Conference materials to include the following:

1. Two volumes synthesizing preparatory reports submitted to the Conference. One will be a compendium of information on State and community activities and concerns relating to children and youth. Data for this volume are now being collected by the various State committees for the White House Conference. The other volume will be an integrated digest of studies and activities reported by members of the Council of National Organizations.

2. Three volumes of "background papers" written by specialists at the invitation of the studies committee: (a) "Perspectives," a collection of historical and philosophical essays relating the Conference stress on values and a changing world to various areas through such topics as "The Older and the Newer Generation," "From Frontier to Suburbia," and "The New World of Science"; (b) "Trends," a group of papers on recent changes in demography, rural and urban life, occupations, women in industry, and other factors influencing family life and young people's futures; (c) "Issues," consisting of papers on open questions affecting children and youth, such as genetic factors in growth and development, problems of minority groups, and the role of government in family life.

3. A Chart Book graphically highlighting factors and trends affecting children and youth today. This will be divided into four main sections: "The Changing World"; "Problems of Children and Youth"; "Current Programs"; and "Projections of Present Trends." The book is being sponsored by the Federal Interdepartmental Committee on Children and Youth, which is providing the data, with the Children's Bureau contributing technical assistance.

4. About 50 "working papers" prepared by persons selected as experts in their subjects, containing resource materials for use in the work groups.

5. The "Conference Workbook," containing the program and questions which may be used as guides for work group discussions.

Family Law

As a first step in the consideration of a plan to set up a research center for the interdisciplinary study of family law at Duke University, the university's law school held a 3-day conference in early April of representatives of various social sciences and professions from both inside and outside the university. Purpose of the conference was to consider the possible usefulness of bringing to bear the points of view and knowledge of such disciplines as sociology, anthropology, economics, psychology, religion, social work, and psychiatry, together with law, in studying the concerns of family law—divorce, separation, adoption, guardianship, custody, support, family courts—in an effort to contribute to the law's objective, the stability of the family.

The 15 conferees included representatives of various schools and departments of the university and 8 persons from outside the university. The latter group was composed of a family court judge, a practicing attorney, two professors of sociology, two professors of law, a theologian, and a representative of the research division of the Children's Bureau. The group saw promise in the proposal and recommended that the possibilities of setting up the center be pursued further.

Juvenile Delinquency

The American Public Welfare Association, in a recently issued statement of policy, urges State public welfare departments to take the lead in planning and providing unified administrative direction to efforts to prevent and treat juvenile delinquency. Pointing out that the prevention and treatment of delinquency require a broad range of facilities and services that affect the well-being of children and youth, the association lists the following among the kinds of services that State welfare departments should "administer, supervise, or directly reinforce through consultation, standard setting, and licensing": social services and financial assistance related to wholesome family living; casework services to assist courts; institutional treatment; aftercare services; consultation to law enforcement agencies; detention; shelter care; fact gathering; and research.

The association recommends that public welfare departments emphasize measures to attract and develop staff "qualified and temperamentally suited to work with adolescents," experiment with new methods and types of services, cooperate with other agencies having common or related objectives, and maintain the identity within their departments of those aspects of delinquency services which are necessarily specialized.

Copies of the policy statement, which is entitled "State Public Welfare Department Responsibility for Leadership in Juvenile Delinquency Services," may be obtained from the Association, 1313 East 60th Street, Chicago 37, at 25 cents each, with discounts for purchases in large quantities.

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Direct observation of inmate systems of correctional institutions by social workers responsible for devising institutional social services was advocated at a workshop on services to groups in correctional institutions, held in conjunction with the annual program meeting of the Council on Social Work Education last January. The participants were faculty members of schools of social work and superintendents and social work staff members of correctional institutions. The entire focus of the workshop was on the implications of the inmate system.

After defining an inmate system as a group response to the institution's system of control, the participants agreed that inmate systems in various institutions differ from each other, and that the nature of the system within a particular institution can only be learned through observation of informal and work groups together with analysis of the factors within the institution's structure which tend to foster antagonism to its purpose.

Such observation, it was asserted, could not be done from behind a desk, and requires a little different perspective and set of skills than most social workers have developed during social work education and noninstitutional experience. It was suggested, however, that a group worker might be helped to move into the situation by his experience with groups.

It was generally agreed that a social worker coming into an institution must enlist the participation of all institutional staff members in designing his plan for providing social services.

Agricultural Migrants

Representatives from 18 States and 18 national voluntary agencies met in St. Louis, April 7–9, at the Mid-American Conference on Migrant Labor, sponsored by the President's Committee on Migratory Labor and the Council of State Governments. The conference included workshops on the following subjects: children and youth, housing and sanitation, public health and public assistance, employment, and governmental and community responsibilities. Among the many actions they recommended were the following:

Enforcement of school attendance laws for all children, including migrants, and making available to schools simple educational records on migrant children.

Establishment of summer schools for migrant children.

Enactment of legislation setting a minimum age for agricultural employment of children outside school hours.

Development of community centers for recreation, day care of children, and health care.

Establishment by local health authorities and medical societies of health services for migratory families, especially in home base areas.

Development by State health departments of uniform health-history cards for migratory families.

Enforcement of State housing and sanitation codes for labor camps and exploration of the possibilities of central housing for migrants.

Study by localities of the feasibility of constructing new housing for migrants or employing nonmigrants.

Appointment of one migrant within each labor camp as a paid sanitary officer to work with a committee of camp residents.

Assumption of responsibility by health and educational agencies for training migrants in homemaking, child care, and nutrition.

Study of the feasibility of developing insurance programs to cover migrants' risks such as sickness, accidents, and unemployment.

Inclusion of the migrant population in the preparation of public-assistance budgets and plans in "migrant-impacted areas."

Cooperation of Federal and State governments in programs to license crew leaders, develop family records, provide safe transportation, license work camps, and distribute surplus commodities.

It was also recommended that the Mid-American Conference on Migratory Labor be made permanent.

Child Welfare

The Advisory Council on Child Welfare Services, established at the direction of the 85th Congress, held its first meeting May 4 and 5 to begin study of the effect of the 1958 amendments to Title V, part 3 of the Social Security Act and to consider the possibility of making recommendations for change, as charged by the Congress. The meeting was largely devoted to determining the scope of the Council's future deliberations and in devising procedures for carrying out the charge. The Council, which is to report to the Secretary of Health, Education, and Welfare and to the Congress by January 1, 1960, includes representatives of public, voluntary, civic, religious, and professional welfare organizations and groups, as well as of the general public.

John C. Kidneigh, director of the School of Social Work, University of Minnesota, is the Council's chairman. Its other members are: William T. Coleman, Jr., lawyer, Philadelphia; Fred DelliQuadri, director, division for children and youth, Wisconsin Department of Public Welfare; Very Rev. Msgr. Raymond J. Gallagher, chairman, program committee, National Conference of Catholic Charities; Maurice B. Hexter, executive vice president, Federation of Jewish Philanthropies of New York; Margaret Hickey, public affairs editor, *Ladies' Home Journal;* H. Harold Leavey, vice president, California-Western States Life Insurance Co.; Leonard W. Mayo, chairman, division of Christian life and work, Department of Social Welfare, National Council of Churches; Joseph H. Reid, executive director, Child Welfare League of America; William G. Stratton, Governor of Illinois; Thomas J. S. Waxter, director, Maryland Department of Public Welfare; and Ellen B. Winston, commissioner, North Carolina Board of Public Welfare.

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Charged with looking into the increase in illegitimacy in relation to the aid-to-dependent-children program, a committee of South Dakota's Legislative Research Council reported last fall that it had found no causal relationship between the two. Attributing the increase in the number of families receiving aid to dependent children to family breakdown due to changes in the economic and social life, the committee recommended against legislation that would place special restrictions on the amount of payments that mothers of illegitimate children might receive and asked that "additional emphasis be placed upon and additional funds be provided for social welfare work within the Department of Public Welfare."

Accidental Poisoning

Children under 5 were the patients in more than four-fifths of the 15,000 cases of accidental poisoning reported to the National Clearinghouse for Poison Control Centers, Public Health Service, during the 3½ years ended December 31, 1958. Practically all the rest of the cases involved persons under 15. Eighteen of the accidental poisonings in children under 15 resulted in death. The poisonings were reported by 59 local poison-control centers, located in 21 States and the District of Columbia.

Aspirin was the top cause of poisoning, accounting for one-fourth of the cases reported. Most of the persons poisoned by aspirin were small children, who swallowed candied aspirin. Children also were reported as swallowing bleaches, detergents, soaps, water softeners, polishes, lighter fluid, cosmetics, insecticides, weed killers, and various kinds of medicines.

The circumstances which most frequently led to the swallowing were: (1) The products were kept in old bottles or food cans instead of their original containers; (2) they were elsewhere than in their usual storage place; (3) the storage place was not locked and was in reach of the child.

The National Clearinghouse for Poison Centers has been receiving reports from local poison-control centers since its establishment in 1957. Most such centers are located in hospitals and maintain 24-hour telephone service, providing private physicians with information about the ingredients of trade-name products and about antidotes and other treatment. If a nonmedical person calls a center, he is given first-aid instruction and advised to call his physician. The first center was established in 1953 in Chicago. (See "A New Life-Saving Service Is Launched," by Edward Press, CHILDREN, May–June 1954.)

Today there are a total of 262 poison-control centers located in 42 States. The principal supporters of the local centers are State chapters of the American Academy of Pediatrics, State and city health departments, medical schools, and local medical societies. Some are financed by parent-teacher associations and men's and women's service clubs.

The National Clearinghouse for Poison Control Centers serves local centers by providing them with information on new products obtained either from manufacturers or from other local centers. When requested, more than 200 major producers of drugs and household products voluntarily inform the Clearinghouse about the ingredients of their products and the antidotes for any poisons in them. The Clearinghouse also assists communities that wish to establish poison-control centers.

Miscellaneous

Reported births of children to American parents abroad amounted to 46,070 in the fiscal year ended June 30, 1958—about one percent of all births recorded in the United States for that period. The number exceeds the birth registrations for the period in 19 of the States.

Reports of children born to Americans outside the country are filed voluntarily with the nearest United States consular officer. He forwards these reports to the U. S. Department of State, which accepts them for permanent filing if the child is an American citizen according to this country's nationality laws. Determination of citizenship is based on such facts as the parents' identification, the precise intervals they resided in the United States and elsewhere, and similar items. Thus, this document will serve the child throughout his life not only to establish the facts of birth but also citizenship.

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To help prevent childhood accidents the American Academy of Pediatrics has issued a set of six 1-page leaflets for distribution to mothers through physicians. The leaflets offer tips to mothers for keeping babies and little children safe. Copies may be had from local diaper services and from the American Academy of Pediatrics, P. O. Box 116, Evanston, Ill.

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The Ford Foundation recently announced a grant of $195,000 to the University of Michigan for a national study of family income, with special emphasis on low-income groups and the causes of poverty, and a grant of $24,850 to support a year-long analysis of research and experimental programs in youth development. Preliminary research in the youth study will be concerned with such subjects as creative leadership and responsible maturity, passive conformity, and rebellious delinquency and will be planned as the basis for long-term studies.

Correction

The homemaker pictured on page 111 of the May–June issue of CHILDREN is with the Family and Children's Service in Minneapolis, where she has been for the past 10 years, and not with the Catholic Charities of Cincinnati.

Guides and Reports

FINDING MORE FOSTER HOMES; a special recruitment campaign, sponsored by the Council of Social Agencies of Rochester and Monroe County, N.Y. 1959. 39 pp. $1.50.

Explains in detail the methods used in a concentrated one-month effort to find foster homes, carried on together by the five child-placing agencies in a county.

COUNSELING PARENTS OF CHILDREN WITH MENTAL HANDICAPS; proceedings of 1958 Woods Schools Conference, held in Minneapolis in cooperation with the University of Minnesota. Woods Schools for Exceptional Children, Langhorne, Pa. 1958. 108 pp.

Includes in the discussions a statement of principles for counseling as soon as retardation is discovered.

CHAPEL HILL WORKSHOPS, 1958. Part 1, Workshops for Houseparents of Children's Institutions. 54 pp. 75 cents. Part 2, Workshops for Executives of Children's Institutions. 36 pp. 75 cents. School of Social Work, University of North Carolina, Chapel Hill. 1958.

Presents reports summarizing the findings of workshops for personnel of children's institutions, held under the auspices of the Child Welfare League of America and the University of North Carolina School of Social Work, July 1958.

REPORT OF NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON MENTAL RETARDATION, 1958. Legislative Document No. 83 (1958). The Committee, Albany, N.Y. 1958. 79 pp. Available on request from the Committee.

Describes New York State's legislative accomplishments for the mentally retarded, the Joint Legislative Committee's proposals for the future, and the progress made by the State departments of education and mental hygiene, the Interdepartmental Health Resources Board, and private groups.

IN THE JOURNALS

Radioactivity Study

High natural radioactivity of the environment was correlated statistically with high rates of congenital malformations in a study of birth and death certificates of more than a million children born 1948–55. The study is reported by John T. Gentry, Elizabeth Parkhurst, and George V. Bulin, Jr., in the *American Journal of Public Health* for April 1959. ("An Epidemiological Study of Congenital Malformations in New York State.")

The New York State Department of Health, which made the study, examined the birth certificates of all the children born in those years in all parts of the State except New York City, and the death certificates of all those who died before reaching their fifth birthday. The certificates indicated that the average malformation rate for all the 946 townships included was 13.2 cases per 1,000 live births, and that in 186 townships it was 20.0 or more.

After a compilation was made of the geological data on the natural radioactive deposits, it was found that the areas in New York State with the greatest amounts of natural radioactive materials are those with outcrops of igneous rocks. These areas had the highest malformation rate, 17.5 cases per 1,000 live births.

Reporting the study, the department notes that the statistical associations found represent only a first step in establishing a possible cause-effect relationship between natural radioactivity and congenital malformations.

Child Care in the USSR

In the Soviet Union great emphasis is put on the care of children, says Leona Baumgartner, M.D., in the *American Journal of Public Health* for May 1959. ("What About Soviet Medicine and Public Health?") The Government operates many nurseries for children from shortly after their birth to 3 years of age, the author notes, adding however that there are not enough nurseries to keep up with the demand. The children may stay at the nursery while the mother is at work, or all the time; mothers are given time off to go to the nursery and breast-feed their babies. A pediatrician is in charge of each nursery and supervises the children's diet, inoculations, rest, and play, and when a child is sick the pediatrician cares for him either in the nursery or at home.

The author notes that in the nurseries she visited there was a high ratio of staff to babies and little turnover in staff—so that the babies got continuing attention from the same person. The children in the nurseries seemed to her to be less spontaneous in their behavior than American children of the same age, but they looked so healthy and happy that she questions whether the evidence against caring for babies and small children in day nurseries should not be reexamined.

Maternity leave with full pay is given to mothers—56 days before and 56 days after the baby's birth, and more if medically needed, according to the author. Most mothers are delivered by midwives under the supervision of physicians. All maternity care is provided by the Government, and the mother of a child born out of wedlock receives the same medical care as any other mother. The author was told that when an unmarried mother names the putative father of her child 25 percent of his pay is automatically withheld for the child's support.

Maturing of Social Work

Mothered by sociology, with psychiatry as a father figure, social casework has passed through a number of developmental stages before reaching its present mature status, says Helen Harris Perlman, professor of social work at the University of Chicago, in *Public Welfare* for April 1959. ("Social Casework Today.") While its early devotion to sociology had resulted in too exclusive an emphasis on the external environmental aspects of the client's life, its sudden shift to an infatuation with psychiatry resulted in an equally exclusive emphasis on the client's "internal environment," says the author. Maturity came, as with all adolescents, she continues, when social casework began to recognize its own sense of identity as separate from that of either of its parents.

With this maturity has come the ability to acknowledge its antecedents; to balance and fuse its "grasp of psychodynamics with its emerging understanding of sociodynamics." Social casework is now increasingly focusing its attention on individuals having trouble in carrying out one or more of their social tasks—being a parent, a spouse, a student, a worker. This focus, she says, of necessity takes cognizance of the client's social environment, which includes the "living network of those people with whom he is in vital interaction." Finally, she adds, it is a mark of maturity that social casework no longer is giving its attention only to persons who want help and are regarded as "treatable," but increasingly considers the possibility of helping people to want help, stimulating them to want to change their standards and behavior.

Family Court Act

In devoting its April issue to family courts the *NPPA Journal* includes the text of the proposed Standard Family Court Act, drafted by a committee of the National Probation and Parole Association in cooperation with the Children's Bureau and the National Council of Juvenile Court Judges. The family court, as proposed, would include juvenile-court jurisdiction as well as jurisdiction over all domestic relations issues. The act also sets up detailed procedures to protect children in detention and during hearings.

Comments on each section give the reasons for the phraseology used and explain differences of opinion among committee members.

Juvenile Court Dilemmas

The essential function of a juvenile court is "to hold the balance true between the interests of the individual and the interests of society," says Eileen L. Younghusband in the *Social Service Review* for March 1959. ("The Dilemma of the Juvenile Court.") This, she says, results in a number of dilemmas, including the necessity to concentrate on the offender rather than the offense without condemning or condoning and at the same time to represent a limit-setting authority. Among the difficulties she finds the courts facing in these efforts are not only insufficiently developed diagnostic and treatment services, but also a gap between the attitudes and purposes of an enlightened juvenile court and the functions of courts in the minds of young offenders and their parents.

The essential dilemma of a juvenile-court system might be summarized by saying that juvenile courts have too much power and too little knowledge, the author concludes.

Some safeguards she suggests for delimiting the power are: clearly defining the acts designated as offenses; ordering the life of the community to make it easy to keep the law and hard not to get caught breaking it; providing good preventive services; protecting persons from wrongful arrest and destructive experiences after arrest; providing the courts with the necessary range of supportive diagnostic and treatment services.

In addition to increased knowledge about the causation of juvenile delinquency, courts need a social philosophy in which the young delinquent is respected and dealt with as an individual human being, the author maintains.

READERS' EXCHANGE

CHWAST: *The "social unconscious"*

In illuminating the crucial problem of conflicting social values in the treatment of delinquents, Lt. Chwast joins the growing group of practitioners and investigators who are calling attention to the social structural dimension of a process which has been traditionally conceived in one-to-one terms. ["Value Conflicts in Treating Delinquents," by Jacob Chwast, CHILDREN, May–June 1959.] It is becoming increasingly apparent that the treatment approaches which are successful with upper-middle-class neurotics are not automatically adaptable to working-class delinquents. While many clinicians have become aware of this fact, psychodynamic reasons have been characteristically invoked to explain psychotherapeutic difficulties with the latter group.

Lieutenant Chwast rightly emphasizes the fact that social-value conflicts may have to be dealt with when the middle-class therapist attempts to treat the lower-class client. He refers to a phenomenon which I have tended to call the "social unconscious." This is a psychoanalytically flavored way of describing the social structural forces which impinge so powerfully, yet so covertly, upon all the vital conditions of living that come under review in the treatment process—philosophical views, interpersonal relationships, and familial and occupational attitudes and goals. Perhaps, having been made aware of the power of the individual unconscious through psychoanalytic discoveries, we must now come to understand the way in which our "social unconscious" weaves itself into every aspect of our lives.

Research in social psychiatry, such as that conducted by the Yale group under Hollingshead and Redlich, has pointed to the strong concentration of psychoanalytic and interpretive psychotherapeutic activity among patients in the upper half of the socio-economic scale. The investigators appear to advocate the development of more "5-dollar therapists" as an answer to this problem. Such a conclusion may be erroneous.

The difference in social values at different ends of the socio-economic scale may actually testify against the advisability of uncritically applying the standard psychoanalytic treatment model to therapeutic problems in the lower-class groups. Rather, it may be necessary to develop entirely new treatment approaches for those whose social values do not reverberate sympathetically with middle-class ideals of maturity, introspection, and deferral of gratification. The traditional techniques might be replaced, not necessarily by a frenetic overactivity on the therapist's part, such as Lt. Chwast seems to suggest, but by the development of entirely new nonverbal treatment techniques.

Certainly understanding of the social structural dimension of the treatment process may yet help to provide a means of breaking through these technical barriers.

H. R. Brickmann, M.D.
Director, Outpatient Department, Neuropsychiatric Institute, University of California at Los Angeles.

JOSSELYN: *A clinician's viewpoint*

Pediatricians who are involved in developing adolescent clinics are most grateful to Dr. Josselyn for indicating a specific supportive role which can be played by understanding physicians, social workers, youth leaders, and teachers in rendering a broad degree of service to the adolescent. [See "Psychological Changes in Adolescence," by Irene M. Josselyn, CHILDREN, March–April 1959.] Such workers should also read her book, "The Adolescent and His World" (Family Service Association of America), for more complete exposition of her concepts.

There is no part of her article which is more helpful than that relating tc the anxiety of professional people in dealing with adolescent clients. An enlightened, sympathetic, but at the same time highly skilled point of view is badly needed in this field of medicine. With less anxiety about the management of the problems of adolescence comes increasing understanding that the growing person derives much strength from the security of limitations and discipline and the fact that some struggle in developing maturity and independence is physiological and probably indispensable.

C. Henry Kempe, M.D.
Professor and Head, Department of Pediatrics, and Chief, Adolescent Clinic, University of Colorado Medical Center, Denver.

U. S. GOVERNMENT PRINTING OFFICE: 1959

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

WHEN YOU ADOPT A CHILD. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 13. 1958 (revised). 28 pp. 15 cents.

Revised after being out of print for a number of years, this publication, planned for couples who wish to adopt a child, includes: information on the adoption process; questions needing consideration by prospective adoptive parents; and advice to those who wish to adopt a child from abroad.

THE PHYSICIAN'S PART IN ADOPTION, CB Folder No. 44, 1958. THE SOCIAL WORKER'S PART IN ADOPTION, CB Folder No. 45, 1958. THE ATTORNEY'S PART IN ADOPTION, CB Folder No. 47, 1959. 12 pp. each. 10 cents each. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau.

Based on three separate meetings of the Children's Bureau with members of the medical, social work, and legal professions, the three pamphlets point out the importance of collaboration among these professions in helping all the parties involved in adoption—the child, his natural parents, and his new parents. The pamphlets stress the responsibilities of each profession to the child, his parents and the adopting couple.

A COMMUNITY PROJECT. YOUTH FITNESS: what a community can do for fitness. President's Council on Youth Fitness. 1959. 16 pp. 15 cents.

Presents suggestions for planning community youth-fitness programs, including a checklist for making an inventory of current activities and needs.

PERINATAL, INFANT, CHILDHOOD, AND MATERNAL MORTALITY, 1955. Eleanor P. Hunt and Ruth R. Moore. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 50. 1958. 36 pp. Single copies available from the Children's Bureau without charge.

Presents in graphic and tabular form data collected by the National Office of Vital Statistics on births and on deaths before, during, and soon after birth; deaths during the first year of life; deaths of children up to 14 years of age; and maternal deaths.

HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY. Concepts and definitions in the Health Household-Interview Survey. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 584—Series A 3. September 1958. 29 pp. 30 cents.

This report presents the concepts and terminology used by the Public Health Service and the Bureau of the Census in the year ended June 30, 1958, in interviewing samples of the population and reporting on these interviews as one part of the National Health Survey. It includes: the design and content of the basic questionnaire; explanations of the interview structure and of the concepts of morbidity, disability, and medical and dental care on which the questionnaire was based; and the definitions of specific terms used.

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SEPTEMBER • OCTOBER 1959

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New Approaches to ADC

Culture and Technical Aid

Studying Infant Deaths

Prejudice and Children

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children ®

VOLUME 6

NUMBER 5

SEPTEMBER–OCTOBER 1959

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READY FOR SCHOOL. The first time in a child's life when he must be really on his own comes for most children on the day they leave for school for the first time. Taking this major step toward independence may be a terrifying or exciting experience, or a mixture of both, depending on the child. Often the necessity of making the break may be more difficult for the parents than it is for the child. (See p. 173.)

◄ *the authors*

Jay Roney's paper on the ADC program is in a sense his "farewell address" as head of the Bureau of Public Assistance, for on July 10 he left the Federal Government to become director of the American Public Welfare Association's new project on the aging. He had been with the Government for 9 years, 5 with Public Assistance and 4 with the Children's Bureau as child welfare representative in the Kansas City regional office. Previously he directed the local public welfare department in Pierre, S. Dak.

Kermit T. Wiltse has been engaged in social work education for the major part of his professional career—at Berkeley since 1950 and previously at the University of North Dakota. A onetime child welfare worker in North Dakota, he received social work training at the University of Chicago and worked as a case supervisor in the public welfare department in Fargo before beginning to teach. His doctorate is from the University of Pittsburgh.

After spending 2 years in India with the World Health Organization, Alfred Yankauer is returning to this country this fall to resume his work as director of the Bureau of Maternal and Child Health of the New York State Department of Health and as lecturer in preventive medicine and public health at the Albany Medical College of Union University. Before joining the New York State staff in 1952, he was in the Rochester health department.

In the 5 years he has been with the North Carolina State Board of Health, James F. Donnelly has also been serving as associate clinical professor of obstetrics and gynecology at the University of North Carolina Medical School. In the previous 10 years he was on the faculty of the Bowman-Gray School of Medicine in Winston-Salem.

With both master's and doctor's degrees in human relations education, obtained at New York University, Rhetta M. Arter was director of field studies at the university's Center for Human Relations before taking her present position. In that capacity she conducted a number of action research projects in intergroup relations in Manhattan neighborhoods which were rapidly changing in ethnic composition.

After teaching social work research for 7 years at the School of Social Welfare, University of California at Los Angeles, Mary B. Novick joined Laurin Hyde Associates, management consultants to social work agencies, in 1958. Previously she was dean of the Graduate School of Public Administration, University of Puerto Rico. During the war she worked in the Federal Security Agency.

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NEW APPROACHES TO AID TO DEPENDENT CHILDREN

I. Through Administrative Policies

JAY L. RONEY
Former Director, Bureau of Public Assistance

How can the Aid to Dependent Children program best fulfill the purpose spelled out in the Social Security Act of "strengthening family life"? The large measure of attention accorded this question at the 1959 forum of the National Conference on Social Welfare held in San Francisco last May reflected the increasing concern among social workers—and the public at large—over the quality of living of the families on the rolls of this Federal-State program of financial assistance to children whose homes have been disrupted by the absence or disability of at least one parent. The articles which lead off this issue are condensations of two of the several papers at the Conference which mirrored this concern.

ALL OVER THE WORLD, scientists are working on the question, "What shall we find when we reach the moon a year or so from now?" At the same time, social workers are facing a question that affects human beings *right now.* This is: "What will Johnnie, or Mary, or some other needy child find when he goes home from school this afternoon?"

Those who work in the Aid to Dependent Children program have seen a grim answer in thousands of troubled families and so are deeply concerned with another question, "What can be done about it?"

The State-Federal program, Aid to Dependent Children, is the largest public program that by providing financial aid and other services helps needy children to remain with their families in their own homes and helps their parents to provide a wholesome home life and to use the health, educational, and other community resources needed by the family.

Some people say that receiving an ADC payment undermines the family's drive to become more independent. However, a welfare worker has called ADC a stopgap measure to give brief and scanty help to the fatherless families having the greatest social problems. The majority of families on ADC receive assistance for less than 3 years. It may well be asked whether many families receive aid long enough really to get back on their feet.

Many people blame the program for the rising proportion of parents on the ADC rolls who are divorced, deserted, or unmarried. As more families are protected by old age, survivors, and disability insurance, fewer widows and their children require ADC, and this, naturally, raises the proportion of broken families on the ADC rolls.

We hear, too, that ADC is largely responsible for the Nation's increasing illegitimacy rate. Does anyone believe that a woman in her right mind would have an illegitimate baby just to get an ADC payment of $20 or $30 a month? And do we also have to remind the critics of ADC that unmarried people were having children long before the passage of the Social Security Act?

Blaming ADC for the appearance of worldwide social problems among our fatherless families seems about as realistic as blaming an umbrella for a thunderstorm.

Many people accept ADC as an umbrella to protect "worthy" widows, "deserving" children, and other "decent" families. But they do not want to share this ADC umbrella with children whose parents have not enough strength, maturity, or money to maintain a "suitable" home. Perhaps these people are afraid that if we were to help children on the basis of their need rather than their parents' marriage certificates we would have to have a larger, and probably more expensive umbrella.

Every effort must be made to see that the ADC umbrella shields the children whom the program was designed to serve. This calls for recognition that the well-being of the child depends on the welfare of the family, which in turn rests, to a large degree, with the parents. Social changes are putting new pressures on family life, and therefore new approaches must be taken to help parents handle old, as well as new, problems. The better the ADC program is administered, the more effective it will be in strengthening family life.

There are two general avenues of approach that can be taken: (1) legislative changes and (2) changes in administrative policies.

New Legislation

There is the possibility of changing legislation so that financial aid and other services might be given to needy families not protected by our present umbrella. New legislation can expand the Federal-State public assistance program to include a fifth category, general assistance, for those not eligible for the existing categories. Or the present four categories might be combined, through legislation, into one overall program of general assistance. Thus, Federal funds would be available to help the States provide aid to all needy people on the basis of their want alone—without restrictions in regard to age, residence, citizenship, or the parents' marital status or employability. Needy parents and their children could then get help before financial and emotional deprivation had permanently damaged family unity, self-respect, and resilience.

We have also heard proposals, over the years, to expand the present ADC legislation to cover all needy children. Our current ADC laws are sometimes interpreted to mean that the child of an unemployed father is better able to live without eating than is the child of a disabled father—or that it is better for a mother to work outside the home, regardless of the emotional needs of herself and of the child who has already lost his father.

But even new legislation will not solve all the problems of all our needy children.

Administrative Policies

Furthermore, hungry children and anxious parents cannot wait for new laws. I believe that through some old and perhaps some new administrative approaches more and improved help might be given to some needy families *now*. Administrative policies and procedures can be examined to see whether they really strengthen family life. Do they respect the parents' rights to make the decisions that affect the family's daily life? Or do they perhaps infringe on the parents' rights and even hinder the family's welfare and development? The quality of administration is often the decisive factor in whether public assistance helps or hinders a person in whatever struggle he is making toward independence and a better life.

In planning for a new approach to ADC, the responsible authorities in some States have been evaluating their public welfare regulations. Some have found that their laws are much less restrictive than their policies. However, their laws and their policies may be more rigid than Federal law.

It is necessary for all States to evaluate their welfare administration in the light of present day knowledge about effective ways of helping people meet social and economic pressures. Public assistance agencies are socially, as well as financially, accountable to the Nation for the families served. Yet there are administrative policies in some States which are more destructive than constructive. For example, many families require ADC to tide them over a temporary crisis, but in some States a family cannot get aid until the father has been away 6 months, or unless the mother is already working to help support her children.

The problem of desertion calls for a complete relook at ways of dealing with this manifestation of marital conflict. What has been the result of court actions to force the father's support, or to make the parents come together against their will? What effect do routine court actions have on children? May not court procedures, unwillingly undertaken, add to the family's feelings of disgrace and undermine the chances for later reconciliation? Furthermore, when enforcement officers make home visits at 4 o'clock in the morning, would it be any wonder if the children had nightmares for months afterward?

Experience shows that voluntary arrangements with the father for his support of the family are generally more lasting and more constructive than court procedures. When making policies in regard to desertion, the State agency should see that every action is based on two motives: to help the father and the mother find ways in which they can best carry their parental roles; and to minimize the scarring experience on the children.

This demands some real consideration of the father's role in the family—whether or not he is in the home. Is his role being strengthened or weakened by the agency's administration? Helen Perlman has said: ". . . even when the father is for the most part out of the home, the child's life is potently affected by him. A mother's love or excessive indulgence, her hate or subtle rejection of her child, are heavily affected by what her husband is to her as husband and to his child as father . . . ."[1]

Work and Money

What approach should the public assistance agency take toward the question of whether or not mothers should go to work? True, in our present society more and more women are working outside the home. But what about their families? I know of one mother who maintained she was not neglecting her 3-year-old son when she gave him money to buy his supper in a restaurant; and of another who, when told she must work, said she believed that her children should be allowed to have at least *one* parent at home.

Good administrators recognize the multiple strain on a mother who also has to be father, wage earner, and homemaker. Moreover, many mothers may not earn enough to pay someone to give their children proper care. Here again a State's public assistance policy should be directed toward the overall goal of strengthening family life.

Money, and its meaning to ADC recipients, is also an extremely important administrative consideration. Families on the ADC rolls are already financially disadvantaged. But not only money is essential in our economy, its possession and use have emotional meaning to the needy family. For example, if a parent uses her ADC check to buy a refrigerator, she may be buying not only better health for her family, but also self-respect, prestige, and community status. Good administration requires understanding of the role of money in the lives of individual clients.

Illegitimacy

Illegitimacy is a nationwide problem not confined to the ADC rolls. But the large proportion of ADC cases involving illegitimacy provides the chief weapon for criticizing the entire program. Unmarried fathers are those least likely to support their children, so it is only logical that the families of many of them require public aid.

I certainly do not condone illegitimacy, but I cannot agree with some of the suggestions we hear on the ways to treat this social problem. For example, in several States compulsory sterilization has recently been proposed as a curb to illegitimacy. Although the law would apply to the State's entire population, mothers on ADC, being most in the public eye, could easily be its chief targets.

Some critics of ADC would aid a mother with one illegitimate child, but would deny help to younger brothers and sisters born out of wedlock. This is certainly a sure way to split a family into pieces.

Other critics would make all unmarried mothers and their children ineligible for ADC and let them shift for themselves at a time when they most need help.

There are many known factors contributing to illegitimacy—unsatisfactory home life, overcrowded housing, cultural patterns, the anonymity of city living, financial conditions, military service, limited education, emotional deprivation, and rejection. These conditions appear again and again in ADC case histories. All society must help combat them.

Like alcoholism, unmarried parenthood does not stem from a single cause, but it has been proved that skilled social casework can help many unmarried parents find more satisfying and more acceptable ways to meet their emotional needs. Public welfare administration has a real responsibility to make casework available to emotionally deprived people, including the unmarried mothers who apply for ADC.

Administrative policies should also encourage unmarried mothers to come to the public welfare agency early enough to get real help. The agency's policy on confidentiality should be well known in the community. Skilled consultation should be available to the mother, as well as medical care and financial aid for as long as she and her child require them and are eligible for them. Furthermore, the agency should make sure that children born out of wedlock get as *much* help as other children—*never* less.

Information Needed

Effective administration is based on knowledge of the families who require ADC and of the factors that cause dependency.

Through such knowledge public agencies can work to prevent further family breakdown. In Washington, D.C., for example, there is a public child caring institution (Junior Village) for the short-time placement of dependent children. This agency made a thorough study of its clients on a selected "census day." The study uncovered the permanent scarcity of jobs in the community and the lack of vocational training to prepare people to earn adequate wages anywhere.[2] The agency is now working with the community to give people more opportunity to be financially independent.

Public welfare agencies need more information about the education of the families on their ADC rolls. Does the parent know enough—even about arithmetic and sanitation—to buy sufficient food and to keep a clean home? Does the mother know the basic elements of child care? Some welfare agencies are arranging for ADC parents to attend classes in family life. The proper administrative approach can make this type of education welcome to many families.

Now that automation is increasingly threatening the jobs of many industrial workers, a public welfare agency needs to find out whether a father or mother on the ADC rolls can learn the skills that will bring in steady paychecks or make the parent self-supporting when the children are over 18 and the family is no longer eligible to receive ADC; and whether the children are being educationally equipped and trained for future employment. Such an administrative approach aids in the prevention of future dependency.

Public welfare agencies also need to understand the cultural factors that may be involved in family breakdown. For example, less than a hundred years ago Negroes in some States were not allowed to marry, but they were encouraged to have children. Is it strange then that in ADC the illegitimacy rate is higher among Negro families than among white families? Let us remember that all culture is learned. If we hope to change patterns that are not acceptable to the larger society, we must give people broader opportunities to learn and to become part of the general culture in our communities.

But let me point out how broader information can give perspective to statistics. A recent study of illegitimacy in North Carolina showed that while 9.3 percent of white illegitimate children in the State were on the ADC rolls, only 8.8 percent of nonwhite illegitimate children were on ADC. Of all illegitimate children in the State, only 9 percent were receiving public assistance.[3] [See page 195.] Thus this State has one answer for the critics who say that ADC fosters illegitimacy.

Social Services

Administrative planning for providing the social services especially needed in ADC should be strengthened. In most cases, the children are with the mother; she must see not only to her children's needs, but also to her own needs for companionship, creative activity, and recreation. If the family is large, she must meet infinite demands on her time, strength, and skill in budgeting.

Most parents on ADC are doing their very best to help their children. But even so, many cannot do the job alone. Through wise administration, the agency can steadily progress in offering services to meet individual needs. I have already mentioned group education. As another approach to strengthening family life, the agency might arrange to provide a homemaker to teach an inexperienced mother how to manage her home and her budget. A few weeks of homemaker service, made available at the right time and in the right way, may bring permanent improvement in the family's welfare. And what do you suppose might happen if, as a standard practice, agencies were to use homemaker service to help educate a parent *before* a decision must be made on removing the children from the home?

The State public assistance agency in Florida has used an interesting and successful technique in planning for more effective services. The agency gave the State welfare board a list of all the services that were needed by its elderly clients. It also listed the limited services that could be provided by its current staff, under existing financing. Believing that the old people should have all the services on the list, the board assumed the responsibility of obtaining additional money from the State legislature to hire additional staff and to train workers to provide more services. Boards and legislatures cannot carry out *their* responsibilities unless the *agency* gives them the pertinent facts. There is need for demonstrations and research on the effectiveness of various types of services and on their costs in relation to the new strength and independence that they develop in ADC families.

Everybody knows that social workers are most effective when their caseloads are of manageable size. However, agencies should reexamine not only the size of the caseloads their workers are expected to handle, but also the complicated tasks assigned to them. A routine procedure of eligibility determination is not likely to foster a warm feeling between worker and client, nor the mutual confidence necessary for them to work together on other problems and needs. Both the agency and its staff should see how they regard their role as dispensers of financial aid. Moreover, administrative policy should be clear about the worker's responsibility for helping families with their environmental problems, as well as with their financial and emotional difficulties. Effectiveness of service demands visits and other contacts more often than once a year.

Some agencies have been making administrative news by calling on doctors, lawyers, social workers, and other professionals to provide consultation to agency and staff regarding ADC problems. In drawing on community experts, the agency is giving its clients the benefits of broad professional thinking. Moreover, the outside experts can help the agency use other community resources for building strong family life.

In its contacts with a needy family, the public welfare agency has many ways to serve as the family's lifeline between its needs, its conflicts, and its sources of help. For example, suppose a disabled father on the ADC roll is so crippled that he thinks he is a family burden. The public assistance worker tells him about rehabilitative treatment and persuades him to apply for it. She keeps his courage up during the tedious treatment. If little Jimmie reacts badly to his father's absence, the worker may help him by arranging for him to join a Boy Scout troop. When the father is ready to look for a job, the worker sees to it that he has help in his search for possible openings. And if he feels he lacks family understanding with his worries, who but the welfare worker helps his family to understand?

Administration is responsible for helping agency staff carry this continuing contact. The provision of "individualized" services will necessitate additional training, smaller caseloads, and more constant supervision. Supervisors and workers alike may need more time to renew their own emotional strengths, resources, and skills. And it is up to administration to see that they get it.

Most States for years have been providing some of their clients with a variety of services. But since the 1956 amendments to the Social Security Act directed the provision of services toward clearly stated program goals—strengthening family life and helping families attain the maximum self-support "consistent with the maintenance of continuing parental care and protection"—and specifically placed responsibility on agency administration, a number of States have moved faster in developing provisions for services.[4]

The Bureau of Public Assistance has been consulting with the States on their administrative planning in this regard. It has found that progress can be hampered by sketchy or obscure policy statements. In some places policy guides seem to tell staff, "Here are some services you might provide if you have the time and ability and interest." In others, the guides are both clear and realistic.

Size of Payments

But will any of these administrative approaches be worth anything unless they are backed up by more adequate ADC payments? Are we, as a Nation, realistic when we expect $28.68 a month—the average ADC payment for the Nation in March 1959—to enable a child to grow into a healthy adult?

Actually, the families receiving ADC have always been the lowest on the scale of financial assistance. In 1950, an ADC recipient received about half as much as a needy old person. In March 1959—despite increases in all assistance payments—the average ADC payment per recipient, $28.68, was considerably *less* than half the old-age assistance payment of $64.34. And in 17 States the average ADC payment per recipient was less than $24 a month—the amount specified in the Department of Agriculture's low-cost food plan (January 1959 prices) as needed for food alone by each individual in a family of four. Thus, in these States, the average ADC payment is not enough to cover a child's minimum food needs, much less his requirements for clothing, housing, medical care, and other necessities.

And what about medical care? Disease and disability strike especially hard on people who are financially and emotionally strained. Preventive medical care is essential to our children's future well-being. Early diagnosis and medical treatment can help parents avoid the prolonged illnesses that can break up a home. Today, medical care for the needy aged accounts for about two-thirds of all vendor payments for medical care in public assistance. The aged need still more care, but until the public assistance program provides families on the ADC rolls with the medical protection they need, can we honestly say that it is strengthening family life?

In my opinion, the American people sincerely want every child to have an adequate opportunity for normal development. The public just does not know, or does not want to think, about these pitiful ADC payments. Public assistance agencies must take the lead in interpreting the needs of families who apply for ADC to the public and its lawmakers.

The Principles

In examining administrative approaches to ADC, five basic factors should be stressed, understood, and clarified by administrators for themselves and all other staff. These are:

1. The fundamental principles and goals of ADC and their applicability to every family eligible for aid.
2. The relationship of these policies one to another, and to the agency's everyday practices.
3. The necessity of spotting discrepancies and of revising and clarifying policies to carry out these principles.
4. The availability of information about clients that will help staff use these policies to strengthen the welfare of every member of every family in the program.
5. The obligation of participating with the community on the solution of immediate need, the elimination of trouble-breeding areas, the provision of appropriate services, and the prevention of further dependency.

Briefly, I think that the most effective administrative approaches to current problems in ADC will be found in testing our planning aganist one question: "Will this action, policy, or procedure do what we want it to do—will it *really* strengthen family life?"

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[1] Perlman, Helen Harris: Social casework today. *Public Welfare,* April 1959.

[2] Health and Welfare Council Committee on Junior Village: Informal reports and action notes. Washington, D.C., 1958.

[3] North Carolina Conference for Social Service, Committee on Children and Youth: The problem of births out of wedlock; a preliminary report. Raleigh, N.C., April 1959.

[4] Social Security Act, Title IV, Sec. 401, as amended 1956.

> . . . While we are not eager in our modern society to accept the mandate to become our brother's keeper, we become exceedingly concerned over how our brother spends his money when it happens to come from tax funds. We expect the impossible and the improbable in terms of superior judgment in handling money, the most skillful buying habits, and a pattern of needs and desires substantially different from those which the ordinary citizen displays in his own everyday living. . . .
>
> It is one of the tragedies of our times that the Aid to Dependent Children program . . . should be so greatly misunderstood . . . Instead of harping on the problems, we should view with great respect the mothers and other relatives who have been able to do such a really decent job in taking care of children in such thousands upon thousands of cases with so little money, in seeing that minimum needs were met on all too tight budgets, in producing really a very good product in terms of the children themselves. . . . Every State has scores upon scores of young people who are good citizens, who pay their taxes, who support their families, who were aided, usually briefly, through the Aid to Dependent Children program when crises struck the family. Have we tried to follow up on these young people? . . . We have been derelict in counting the values of the program because we have been so overwhelmed by the problems.
>
> *Ellen Winston, North Carolina Commissioner of Public Welfare, to the 1959 forum of the National Conference on Social Welfare*

NEW APPROACHES TO AID TO DEPENDENT CHILDREN

II. Through Levels of Service

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SINCE SEPTEMBER 1958 I have been engaged in a project in the San Francisco Department of Public Welfare. Simply expressed, the purpose of this project is to explore the question, "What does a service emphasis really mean with reference to the Aid to Dependent Children program?"

I find myself deeply concerned and troubled about the whole ADC picture. Part of my concern comes from the current rash of attacks on the program, and particularly the development in a number of States of restrictive legislation. Such legislation seems to me to be a symptom of dissatisfaction with the answers social workers have thus far been able to provide to the public's questions about the program. Perhaps it is inevitable that the rising costs of the program bring about this dissatisfaction even though much of this increase is known to be directly related to the increase in population and hence in the numbers of families and children in need. It seems high time that public welfare administrators provide more imaginative leadership in creating understanding of the program, particularly in the legislatures.

First of all, administrators need to be much more effective and aggressive in exposing some of the fantasies that exist about the nature of this program. One level of criticism should be labeled for the hypocrisy it really is—the assertion that the ADC program is so expensive that its cost is going to swamp the economy. While our society quibbles about amounts invested in families and children it spends lavishly on freeways, ball parks, and thousands of other *things.* Actually, behind the proposals for restrictive legislation, sometimes supported by public welfare administrators, lies an inability to recognize the simple fact that people are just as, or more, important than all the things in which society is willing to invest.

Today's Caseloads

When the 1956 amendments to the Social Security Act put a new emphasis on service for the public assistance program, many people in public welfare hailed this as a beginning of a new era which would eventually change the nature of ADC administration. However, unless the administrative agencies receive support from their legislatures and the funds necessary to follow through with this emphasis, such directives only widen the gap between what these agencies are supposed to do and what they really can do. It is futile to expect the average ADC worker with a caseload of from 80 to 150 cases even to know what services to individual families might be needed or what could be achieved through them, much less to perform them. Questions of education and skill are beside the point when such caseloads prevail. Granted a worker even with this kind of caseload can do some helpful things for some clients, but really to test and demonstrate what can be accomplished with individual families is quite different.

The gross change in the nature of the ADC caseloads over the past several years is well known. Today the large proportion of ADC dependency is due to divorce, separation, desertion, or out-of-wedlock births. While this change has been taking place, migration has brought to our northern cities an influx of minority peoples, particularly Negroes from the Southern States. The central part of the cities are occupied largely by old people and minority groups, while the young families of the middle class have moved to the suburbs.

Ramifications of Change

These changes have many political and psychological ramifications, including the community's perception of the ADC program. This perception involves a complex and interrelated series of dynamics in which differences in cultural heritage and class and the factors involved in racial discrimination are inextricably intertwined. Yet, legislators and public welfare administrators alike are not facing honestly the factors of racial differences and discrimination in the attack on ADC. There is a conspicuous lack of new and imaginative approaches to the program.

Among the restrictive measures that have been introduced in State legislatures is one that would deny aid to the second illegitimate child in a family and another that would refer families having more than one illegitimate child to the juvenile court for investigation of neglect. If such measures should become law they would just exacerbate the problem, not only by increasing the deprivation of children but by intensifying the atmosphere of rejection and denial in which so many of these families live. Such an attack can only stimulate counterattack, for one of the many dynamics that operate in some ADC recipients is a clinging to dependency upon public assistance as a passive expression of hostility toward a depriving and denying community.

How can thinking people support the idea of denying aid to a second child born out of wedlock? On one hand, everything in the culture—TV, movies, newspapers—glorifies sex; on the other hand, we condemn its natural result. If we are going to punish the ADC mother not for her act, but for the result of the act, we certainly need to offer her every opportunity to avoid this dilemma. In addition to the availability of such "resources" as sex education, there must be a degree and quality of help to individual families that at this point few communities envision, much less provide.

My work in the San Francisco project has given my colleague and me some exciting insight into the potentiality for social work services in ADC. It is exciting because of the challenge and potential, but maddening when we contemplate what it will take to realize this potential in increments of personnel, both in quantity and quality, and in changes in the structure of the program to orient it to supporting truly the social work objectives of ego development and rehabilitation in clients.

In working with a small, selected sample of ADC cases, using both individual and group approaches, we have become impressed with the movement achieved by these families and with the potentials for continued movement if someone could continue to work with them. The experience tells us that there are many families in ADC where people, particularly the parents, have a basically sound ego structure, but are so battered and depressed by current problems as to seem much sicker than they really are.

The Service Potential

My colleague has frequently remarked about the contrast she sees between this group and the people she once worked with in a school guidance clinic. Here she is working with people who are primarily representative of lower class attitudes, beset with a galaxy of social problems, but usually very responsive to our support and concern. They are able to mobilize themselves to change their situations quite rapidly. This is especially true of the families which have not long been receiving assistance. In the child guidance clinic she largely saw middle-class neurotics with problems less responsive to supportive help and much slower to change.

We have learned anew that poverty is hard on people in this society, which puts so much emphasis on material satisfaction not only as a symbol of success but also as the very substance of a meaningful life. Having to depend on an ADC income means deprivation of material satisfaction, which in turn means for many persons a denial of the very essence and purpose of living. Material deprivation might be quite differently felt in a culture in which people are not subjected to a constant stimulation to buy and to own.

One cannot listen to ADC parents talk of their struggle to find meaning in their own and their children's lives without realizing sharply how in our culture constant material deprivation saps the very substance of the ego. We have observed the operation of a vicious circle of poverty and emotional depression. Lack of material satisfactions and an available way to obtain them connotes failure and inadequacy; the sense of personal inadequacy yields depression of feeling and acting; this depression diminishes the very activity that might counteract its sources.

We have frequently noticed a kind of subclinical depression in many ADC clients, particularly, but not only, in their early days of becoming a recipient. It is manifested by a progressive withdrawal from all kinds of activities and relationships—hobbies, efforts toward employment, friends, and neighborhood groups. This depression is complicated by a variety of physical symptoms more or less clearly arising from it. The task of the public assistance worker is, in a sense, to counteract it.

Involving ADC clients in group discussions and activities is one way of counteracting such withdrawal tendencies. The potentialities in this approach in working with ADC recipients have as yet scarcely been glimpsed. There might, for instance, be group meetings at intake for informational purposes, discussion groups oriented to therapy, and even client advisory councils to adminstration. I truly believe that if public assistance administrators, particularly State and local welfare commissioners and boards of supervisors, used client groups as a mechanism for really listening to the effect of the ADC experience upon recipients and their perception of the program, these administrators would never feel or act the same again.

A Professional Challenge

In our project, we are recognizing that social work with its appreciation of ego psychology has in ADC practice a particularly fertile field for professional exploration. We have found that while many ADC recipients are beset with problems of day-to-day living and depressed by the psychological buffeting of constant material deprivation and their own sense of inadequacy, they are very responsive to support. When the worker helps them to use medical and dental care, he is helping them to improve not only their health but also their physical appearance and their sense of their own worth, and is communicating his steady concern for them into the bargain. This is but one illustration of the opportunity available to the ADC worker to make psychological ego support a tangible and potent force in helping the client gain renewed inner strength. However, unless the worker's "giving" is guided by clear knowledge of ego psychology that tells him when to give and when to hold the client to an exercise of his own capacities, indiscriminate giving may impede growth.

The professional satisfactions available to the social worker in ADC are in seeing his clients "blossom" by making dramatic changes in their way of living, their relationships with their children, and their use of community resources. Effective service to ADC families holds tremendous potential for conserving the community's human resources, preventing more serious problems, and saving public funds. However, we are so far short of realizing the potential for service in ADC that it is anguishing to contemplate the long road ahead.

Inevitably any discussion of ADC comes to the problem of the lack of sufficient and competent personnel. Each fresh look I take at the ADC program convinces me that it should have top priority in the demand upon the resources of the community devoted to social services and in the interest of the social work profession. The ADC program profoundly affects the lives for good or bad of more children at their most formative years than any other social welfare program. I think the fact that so few social workers are really interested in ADC is a major reason why real social work service to ADC families is still more of a dream than a reality.

Why do so few professionally educated social workers seek to build a career in ADC practice? Is it that too many of them lack the kind of professional commitment that would lead them to brave the frustrations and exigencies of public assistance work—the low salaries, unattractive working conditions, mounds of paperwork? These factors play an important part. However, I believe one reason is that social workers have not glimpsed the program's potentialities.

Design for Progress

Nevertheless, I do *not* think that progress cannot be made toward improving services in ADC until these programs are fully staffed with professionally educated social workers. Our present ADC workers can accomplish much now if they take the time really to listen to people and are supported by the agency's structure to do all the helpful things they can. I am also aware of the necessity for these workers to have the stimulation and guidance of persons with knowledge of ego psychology and the capacity to teach others how relationships can be helpfully used.

I have furthermore concluded that clinics should be developed within the structure of public welfare departments. I say this not only because of the shortage of community facilities of this type and the loss of time and energy that goes into making referrals. I believe that at this time a full-fledged psychiatric clinic within a public assistance agency by its very existence would help to change the public's, including the client's, perception of the agency. What is more important, clients would be held much more easily and more effectively to using such a service.

The community should not be willing to sit by while children are destroyed by destructive parent-child relationships. If the public welfare department had an outpatient clinic within its own environs, the client who needs therapy in order to carry his parental responsibilities or to function in other ways in a socially responsible fashion could be held to using the clinic. I am suggesting that this kind of social responsibility should be demanded in return for the check.

I realize that this bald suggestion may raise the eyebrows of social workers and the objections of public welfare administrators. However, I believe that many ADC recipients do want help, want to be held to using it, and are unable to use it as offered by the voluntary community agencies even when available. I am convinced that such a clinic would in many instances avoid expenditure of much larger sums for institutionalization of disturbed persons and the placement of their children.

Levels of Service

Three general levels of service are necessary in regard to ADC cases. They are:

1. Standby, with minimal involvement of client and worker in a treatment relationship.

2. Reaching out actively, aggressively, and supportively to help the parents and sometimes older children use agency, community, and their own inner resources to improve their functioning.

3. Therapy, the use of a treatment relationship as the medium for helping the client to examine and resolve his inner psychological conflicts.

I visualize the first two levels of service as being performed by units of ADC workers and supervisors as typically organized in our agencies at present but with some changes in alignment of personnel; and the third level as being performed by the professional personnel of a clinic set up within the public assistance agency and identified by the client and community as a part of the agency. The clinic would be directed by a psychiatrist and staffed by social workers and psychologists.

The ADC units would be staffed by social workers with a fairly wide range of educational and experiential backgrounds. I would guess that each unit might have at least two workers prepared to use relationship as the primary tool for helping disturbed and disorganized persons mobilize themselves to change basic ways of functioning in relation to children, employment, and other social realities. These workers would have to have professional education in social work and a caseload small enough to be able to know and work with each family in a consistent way—certainly not more than 25 cases at a time.

Obviously overall direction and supervision of such ADC units would be of crucial importance because diagnosis, in order to move cases to the person or the place where they can receive the appropriate level of service, is the key to success. Moreover, a teaching-learning atmosphere in the unit is essential if each worker is to examine each facet of each day's work in the light of the question, "What is the problem here, and how can the agency better deal with this problem?"

Some Illustrations

The following brief case stories exemplify the three levels of service:

Mrs. A. aged 37, has six children, the product of two marriages, both of which ended in divorce. She manages her home and her household acceptably. Her children get along satisfactorily in school and in the neighborhood. She is aware of the medical and other community resources, and uses them independently and appropriately. Although she looks tense, she is well controlled, and responds warmly and appropriately to her children. Her ego defenses seem to be adequate and largely appropriate. Her chief problem is managing on the very limited ADC income. Her family is an example of service level 1.

. . .

Mrs. B is an example of service level 2. Deserted by her mother at an early age and reared by a grandmother, she experienced a very troubled adolescence, resulting in pregnancy at 14, followed by a troubled marriage and a succession of children born in and out of wedlock. Still very young and the mother of five children, she is poorly equipped for adult functioning. She feels no one has ever really consistently cared about her and in consequence makes a demand for just this kind of caring from the community through the public assistance agency and its social worker. With consistent concern and support from the social worker in dealing with concrete problems, she can meet the demands of day-to-day living and those of her children reasonably well; without it, she almost literally falls apart. Obviously, the worker's investment of time in this case is of tremendous significance in terms of prevention.

. . .

Mrs. C is an example of a person who needs immediate help with her emotional problems under psychiatric supervision. She is the mother of two children, who are now at an age which might logically free her to seek employment; yet emotional

problems, the source of which is not now clear, have incapacitated her with severe and dangerous depression. An ideal candidate for outpatient therapy, she may or may not get herself to and consistently use one of the community's clinics. She has had a long and generally satisfactory relationship with the public welfare department. In an atmosphere of acceptance but clear expectation that she use clinic help, she would engage herself with a clinic at the department, if there were one. Help to this seriously depressed person should be rendered only under medical supervision.

As I try to visualize what is necessary to do the service task in ADC, I come to the need for large increments of trained and experienced personnel. The fact that this plea has often been expressed before is depressing in view of the small gains that have been made. Yet the suggestion is intensely practical, if we realize the opportunity for service to families on the rolls and the tremendous human and social waste of the failure to perform such service.

In our project we have seen the remarkable things some ADC recipients can do with themselves when they are helped to understand the problems that oppress them and are given psychological support for a fresh attack. On the other hand, families on ADC deteriorate because of lack of such help or occassionally from the inept attempts of a harassed worker to discharge impersonal agency mandates. We see children literally "getting more disturbed in front of our eyes," and can only imagine the personal and social loss caused by the community's failure to render through the public assistance agency the kind of preventive and restorative services needed.

Over the years some gains have been made in securing more professional personnel for ADC programs. But they seem infinitesimal when judged against the size of the problem. We must, I think, go on to the offensive on the theory that as taxpayers we are sick and tired of the social and economic waste inherent in the community's failure to provide preventive social services in this program that holds such a great potential for promoting healthy family life.

FIRST DAY OF SCHOOL

I believe the most stirring moment in the experience of a parent comes on the day he leaves the child in school for the first time. This can be so sharp an experience that, where there are two or three children, this ritual has to be alternated between parents. I remember leaving one of mine there all starched up with a look of bewilderment on his face such as I never want to witness again. I held his little hand and got him registered. As we walked through the yard and corridors of the school, he never took his eyes off me, and never said a word. Then came the moment to put him in a line and—leave him.

I tried to be nonchalant as I walked away but I quickly hid behind a pillar; he had never taken his eyes off me. He just looked and looked, and I could see that he filled up, but, since I am bigger, I filled up more. What an ordeal! Yet I knew that the final decision could not be delayed for long. There was no law that forced me to keep watching him. I turned my back and started out slowly and then I practically ran out the door. You have to make a break.

Harry Golden in Only in America, *published by World Publishing Company.*
(Copyright 1958 by Harry Golden.)

An American pediatrician in India reflects on problems of . . .

INTERCULTURAL COMMUNICATION IN TECHNICAL CONSULTATION

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LIVING and working in India for the past 2 years has been a rewarding personal experience—but a jolting one. The jolt was greater than I had anticipated, and I sometimes wonder whether my advance acclimitization could have been improved. I can think of only two small experiences which might have helped. Both are sounds—the sound of music and the voices of people talking. It is possible that hearing these strange new Indian sounds might have prepared me for living among the people who made them. For both the music and the voice tones express the direct feel of a way of life and a pattern of human relationships and values. It is the feel of these traits and the expectations aroused by them that the stranger needs to experience in advance if he expects to begin to adjust in advance.

This stranger—student, teacher, consultant, or administrator—bridging an affluent society with one euphemistically called "technologically underdeveloped" is becoming a common breed as the world shrinks. Some day, no doubt, when the world's grace is more evenly distributed among its peoples, the gaping contrasts and contradictions he must bridge will be less severe and his adjustment easier. Meanwhile, his very commonness demands a decent respect for the problems which beset him. The impact of a new set of cultural values upon him, and his reaction or adjustment to them, are obviously pertinent to the success of his mission.

This impact is bound to be conditioned by many personal factors, such as the integrity of the stranger's personality, the personalities and needs of his dependents, the physical conditions of his current life, and the value conflicts of the two societies being bridged. However, the nature of the stranger's mission in itself has an important effect upon this impact. It is the mission which defines the roles which he is expected to play, which he himself anticipates, and in which cross-cultural contacts are made.

The stranger today no longer comes openly as the representative of a dominant culture imposing its will, nor can he afford to insulate himself from the life around him by building physical and social replicas of his homeland, although both of these tendencies linger to some extent. He comes today, usually, as a professional person in an overtly stated role. Obviously the role of an anthropologist, who comes only to observe, interpret, and analyze the culture, is perceived differently from that of the active participant who comes to teach or organize, to build, or in some other direct way to interact with other men.

Moreover, as participant, or doer, the nature of the technical consultant's participation affects his role. His participation may be only in sharing the existing workload, lending another hand, reducing the shortage of professional services, or it may be in changing and developing, or, at least, in being a symbol about which the expectation of change revolves. As "changer-developer," the extent of his authority—to command directly or to recommend action for others to take—affects his role.

The overtly stated role of the technical consultant is only a portion of his perceived role, however. Apart from the clinging suggestions of colonialism, the dynamics between government and agency, requesting assistance on the one hand and supplying assistance on the other, affect the role of the technical consultant. Any request for help may arise out of valid insight, or out of pressure and a desire to please, unrelated to the task at hand. The request for personnel, or the commitment to change, may be accessory to a more deeply felt need for equipment or financial aid. On the other hand, the giving of help may be motivated solely by a sense of human decency and need, or it may be ulterior to political and military aims. All of these factors, or at least the perception of them by the stranger and the persons with whom he interacts, will affect the role in which he is cast and thus the width and depth of the cultural gaps which he must bridge.

Social workers, particularly those concerned with welfare assistance programs, will be familiar with the principles behind these factors for they operate in affluent societies also. They affect the nature of social casework and of agency program and the character of staff "consultation," "supervision," and "inservice training." Nor is any given situation ever purely black or white. Most often in the case of the client seeking help, the legislator voting on agency funds, or the staff member with a problem, there are motives which conflict with each other. The depth and extent of this ambivalence and the way it is balanced are what give individual coloring to each program. It is the same in principle with international assistance, plus the addition of a cultural gap between the giver and receiver which is inherently broader and deeper than that between an upper-middle-class social worker and a slum-dwelling welfare recipient.

Although the technical consultant may be aware of the breadth and depth of this gap, whatever his mission, the way in which he feels its impact is dependent upon the role his mission assigns him. In some way this mission is usually concerned with the transmission of technological skills and knowledge. Although this seems like a straightforward problem in communication, the application of these skills and knowledge may clash with culturally conditioned values; or more commonly, the important aspect of the skills themselves is a general principle whose application is inhibited by such values.

For example, medical education in America could be fairly described as aiming to teach the student how to think clearly and independently in medical terms, where to go for help or detailed information, how to set up and critically evaluate experimental or clinical data. The quantity of technical information which the student learns—above a certain minimum—is less important than his grasp and use of these abstract principles. These principles and the way they can be taught are in direct contradiction to the traditional Indian idea of learning by sitting at the foot of one's guru [teacher], feeling, memorizing, and imitating. In part these contradictory approaches to learning may reflect an intuitive-feeling-mystical view of life as against an observant-manipulative-pragmatic approach which is also called scientific method. In part they may reflect the paternalistic authority of the Indian joint family as against the self-determination of the Western nuclear family. However viewed, they reflect a nexus of values and expectations, transmitted as part of a culture and operating in the mind of an Indian medical student, which acts as a barrier to the transmission and application of an essential element of Western technology.

The example can be carried a step farther into the realm of institutional organization. The multiplicity of causes that operates to produce a given disease in a given patient have in recent years forced the medical curriculum in America to take on a vertical rather than a horizontal look with the focus on the patient rather than the disease as a unifying element. To do this requires coordination and teamwork between several departments. This is a step that is far easier to take in the gregarious extraversion of

A mother who has moved in with her hospitalized child, an accepted custom in India, which may cause a Western adviser to reflect on the difficulties of comparing the values of protecting children from germs or from emotional trauma.

Left, a woman holding her little girl still while inserting food in her mouth, a procedure often used by mothers in India for feeding children up to the age of 2. *Right,* family life in a compound in the center of the city of Madras. Such differences from his accustomed culture are apt to hit the Western technical adviser with an unexpected impact.

the traditional American community than in India, whose past tradition of community structure was one of rigid compartmentalization by caste. The rigidity of this tradition and most of its outward trappings have been modified tremendously in the 10 years of India's independence, but its unconscious internalization as a way of relating and connecting one's own work to the work of another in a different field is not easily modified.

Values and Cultural Change

Willy-nilly, if he is to fulfill his mission, the technical consultant must become involved—and involved in a major way—with the forces and direction of cultural change. Indeed, in one sense the whole concept of technical assistance could be viewed as a bridge to promote cultural change and the principal mission of the consultant considered to be the transmission of fresh values rather than of specific information or skill.

This poses some serious questions about choice of value systems between different societies; it appears to force a choice which can only be made on philosophical or religious grounds. Promoting cultural change implies that the technologically superior society also possesses a superior culture and system of values. This is a highly debatable proposition in today's atmosphere of threatening atomic destruction.

Therefore the technical consultant must try to learn, understand, and emphasize the strong points and superior values of the culture in which he works as well as the one from which he derives. If this is asking too much of human judgment, he must at least be aware, and make others aware, of his own and his culture's fallibility.

It is far easier to express than to believe in the pious hope that cultural change in a technologically underdeveloped society will mean change only of the weak or detrimental values of its culture, while its strong points are retained. Many observers have pointed out, for example, that in the past there was no need for institutions to care for the chronically and mentally ill, the aged, or the orphaned child in India because all were cared for within the bosom of the joint family. The hope has sometimes been expressed that by emphasizing this positive contribution of Indian society to social welfare there will be less need for the state to organize care for dependents of various sorts. There were other virtues to the large joint family also, but in an atmosphere of technological advance and change only its evils seem to be apparent to many people.

When I discuss this question with medical students they are quick to point out the stifling of initiative, the submission to authority for authority's sake, the lack of incentive to personal growth, and other unpleasant aspects of joint-family life. And they have pointed these things out with a feeling and conviction that can only have been born out of their own or their parents' experience. As the joint family disappears, homes for the aged, sanatoria for the mentally ill, and all the institutional paraphernalia of an industrialized society must be created. There seems little hope of retaining the idea of sheltering the helpless and dependent as a family duty without also retaining the whole joint-family concept and practice.

These same students, when they are asked to name some of the desirable and undesirable child-rearing practices in India, will identify undesirable traits with the greatest of ease but will name desirable ones only after much prodding. The prevalence of breast feeding, for example, which is one of the most striking differences to Westerners, is rarely mentioned. There have been many speculative discussions of the trend away from breast feeding in technologically developed societies, but one obvious reason for it is rarely mentioned. In India if an infant cannot be breast fed, he will very likely die. Few women could fail to respond to such a threat with a full supply of breast milk, and the will to nurse their baby. Technological development diminishes this threat and thus the compulsive stimulus to breast-feed. Can the benefits of technological development be introduced into a society without adversely affecting the incidence of breast feeding?

Unclear Issues

This does not mean that one should give up trying to prevent the undesirable aspects of Western child-rearing practices from affecting the underprivileged portions of the world. Knowledgeable pediatricians all over the tropics today are battling to retain breast feeding as a child-rearing custom. They battle also against the introduction of expensive proprietary milk products into societies that have little need for them and can ill afford them and where their use creates additional hazards to infant health and survival. This kind of issue is clear enough.

However, there are other issues of conflicting cultural practices or values where the issue is far from clear. Toilet training and attitudes toward defecation are an example of this. In the West we have come through an era of rigid toilet training with attitudes of squeamishness and disgust toward fecal wastes into an approach we hope is less fraught with emotion. One of the observations which influenced this trend was that in less technologically advanced societies, children did not need to be toilet trained. They learned quite easily and early to control the elimination of wastes simply by watching and imitating their elders. Rather than resulting in more cases of enuresis, this casual attitude seemed to have the reverse effect, so that there seemed to be no rational basis for rigid and early toilet training even when disregarding its role in adult personality formation.

When Indian medical students read in Lawrence Frank's "The Fundamental Needs of the Child"[1] that "constant reassurance during toilet training" is a "fundamental need," they are usually astonished because they would never have thought of so specific a "fundamental need." The child may need reassurance in the face of anxieties in general, but no more in the case of learning to control his elimination than in learning to walk or talk.

This attitude is so much saner and psychologically sounder than the usual attitude of the Western medical student that one almost hesitates to ask whether it is also as sanitary and as physically safe. Yet no one can be in India long without becoming aware that the practice of promiscuous defecation and its tolerance—indeed its acceptance—is an important contributor to disease and death. Beneath the indigenous witticism relished by the educated Indian—"an Englishman eats in public and defecates in private," while an Indian eats in private and defecates in public"—lie the barbs of typhoid fever, dysentery, diarrhea, and intestinal parasitism. While approving the casual ease with which children learn to control elimination of wastes, one must condemn the attitude of tolerance to insanitary practices which seem to accompany this way. One wonders whether it is possible for this learning process to remain casual and free of emotional overtones, yet produce the kind of community intolerance of insanitary practice that will really effect change. Again we know enough only to ask the question, though we must act as if the answer were "yes."

Inevitability of Change

Whether changes in the culture of an industrializing society are for good or ill, the one thing certain about them is their inevitability. It is even less possible to turn back the movement of urbanization and mechanization or production in the world today than it was in the days of Rousseau and Thoreau, whatever one's feelings may be on the subject. The pace of the change and its accompanying uncertainties are more pronounced in nations undergoing technological development today.

The uncertainty, stress, and discomfort which rapid change produces give the technical consultant a special role to play as a sustainer of morale while at the same time trying to act as an agent of change. In order so to perform however, he must believe—have faith—in the ability of a technologically advanced society to serve truly the cause of human dignity and spirit, rather than solely the cause of materialistic comfort.

This is a faith that may be hard to uphold at times. However, it is only by virtue of such faith that one can admit to some of the symptoms of social illness in Western society, such as rising juvenile delinquency and divorce rates or unabating friction between races and between nations, without interpreting them as signs of decay. These symptoms were well known to the medical students with whom I met and they derived satisfaction from pointing them out. So many comparisons between technologically underdeveloped and advanced countries in the realm of health and welfare place the former at a disadvantage that this reaction is understandable.

To deny, defend, or minimize these social evils only serves to antagonize, to accentuate superficial Western superiorities, and to make less acceptable the deeper values which can really contribute to human welfare. To accept these evils as elements of weakness while pointing out that they are balanced by expressions of social good, and that value judgments must be based on the cumulative effect of all the expressions of a society, should promote favorable change in a more acceptable way.

Culture and Practice

Some recognition of the personal impact of changing values and aspirations on the people with whom the consultant works is necessary. Yet this recognition need not imply any sacrifice of essential goal. The experience of sitting in a small discussion group with an instructor was new to the medical students with whom I worked. Since we had only four or five meetings together, they never became completely used to it. Their participation increased, however, as the sessions progressed, and at times, they even disagreed with their instructor. There was a noticeable difference in response between men and women students. Five sessions (with a few individual exceptions) were never enough to give the women sufficient assurance to talk freely. For this it was necessary to make allowances in assessing performance.

Perhaps the accent I have laid upon culture and cultural change is influenced by the fact that my discussions with students and the clinics which I helped to establish focused mainly on these things. The nature of my mission was to emphasize preventive work and health education in pediatrics and to try to integrate them with therapy. Such an emphasis immediately accentuates the nature of culturally conditioned behavior, especially as it relates to the feeding and rearing of children. In discussing these matters, it was obvious that I, a stranger with no knowledge of the language, could not be expected to know anything about such behavior. I had thought that medical students, who generally come from higher social strata than clinic patients (as in the United States), might also be unaware of the customary practices of lower class patients. I did not find this to be the case.

Class or caste differences in child-rearing customs—at least customs affecting physical health—are apparently minimal within the same geographical area of south India, so that the students knew about prevalent child-rearing practices out of their own personal experiences. They enjoyed regaling me with reports of practices which they knew differed from those of the West, and encouraging this became a way of involving them in discussion. Although aware of the existence of "harmful" practices, they did not always appreciate their significance, relationship to disease, and the need for their recognition in diagnosis, treatment, and preventive efforts.

For example, these medical students knew the system of classifying foods and diseases as "hot" or "cold," a system found in the folk tradition of many parts of the world as well as in Ayurveda, the indigenous Indian system of medicine. They might also be aware of the fact that a child's diet would often be drastically modified in the presence of diarrhea (in accordance with the rules of the "system") with the result that protein-containing foods would be reduced and the child precipitated into acute symptoms of protein deprivation or "kwashiorkor" a far more serious condition than the diarrhea itself. But translating this knowledge into the practice of inquiring routinely about dietary change in *every* case of illness and advising no change or a change consistent with both the maintenance of nutrition and the rules of the "system," was for them a new way of approaching medical practice. It added something new to the obligation of the doctor and to the doctor's expectations of himself. An Ayurvedic practitioner would readily have accepted this obligation by giving great importance to dietary history and advice. However, "modern" "scientific" medicine leads the Indian student to focus on diagnosis of immediate presenting symptoms and treatment in terms of drugs and surgery. He shuts out of mind this pervading relationship of diet and disease which both he and his patient carry with them as their cultural heritage.

The importance of inquiring about diet during illness can be emphasized as a specific teaching point and lead to its becoming routine. Yet this is only one small isolated practice. Its specifics may be far less important to learn than the change in values and expectations which should be associated with it: the challenge to observe and judge independently, to view responsibilities for health comprehensively at all times, and to act accordingly. Such principles cannot be taught or learned through memory or drill. They have to be absorbed by personal experience of a positive nature. The encouragement of such experiences by fostering in others the initiative to create, plan, and execute out of raw elements is an important aspect of the technical consultant's job, whatever his area of professional skills. From time to time the goal of encouraging incentive and self-confidence may conflict with other goals. In such an instance a decision to sacrifice one of the two has to be made.

In setting up a procedure for holding group meetings for mothers to discuss nutrition, I asked our staff nurses to develop and plan the steps rather than telling them precisely what steps to carry out. Unless their methods and content were very wide of the mark—so wide they might actually endanger success—I always accepted them, even when I was aware of a more efficient or skilled way of doing the same thing. It seemed more important in this case that the nurses develop confidence in themselves in a role to which they were unaccustomed and one which could later be extended into many other activities beyond the planning of nutrition classes.

Obviously this kind of encouragement must be based on careful judgment. A doctor or nurse with the best intentions and greatest self-confidence in the world is worse than useless without a solid background of technical knowledge and skill.

Actually, in a developing country purely technical skills and information seem to be best and most efficiently transmitted through teachers from a technologically underdeveloped society who have had a period of study and work experience in a technologically advanced society. It is not so much the skill itself which the visiting technical consultant can help to transmit as it is the point of view and way of life necessary to its acquisition in the first place; not so much the details of knowledge as the value systems necessary to the continuing growth of knowledge; not so much the specifics of a professional discipline as the principles of organizing and applying this discipline in the service of society. It is easier to express these ideas than to know how to carry them out.

I must end by pointing out the obvious fact that I have recorded personal experiences and personal reactions. These arose from only one experience of 2 years in one community, Madras. Apart from the special coloring of my own biases, the limited character of my experiences would make it hazardous to generalize from them. One generalization I feel I can make relatively safely, however: whatever the effect of the technical consultant's mission on other people and places, the effect on himself is apt to be profound.

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[1] Frank, Lawrence K.: The fundamental needs of the child. (Revised edition.) National Association for Mental Health, New York, 1952.

Perhaps the most important missed opportunity in our headlong assimilation of the ethnic groups has been our failure to learn cross-cultural understandings. . . . We need to understand that men may profess other value systems without being devoid of virtue, that they may behave differently without being either stupid or perverse. We must understand that ways of life unsuitable for ourselves are parts of historically developed cultural systems which may deserve our fullest respect. . . .

Ralph L. Beals to the 1959 forum of the National Conference on Social Welfare

In following up clues provided by vital records, North Carolina demonstrates ways of . . .

IMPROVING MATERNAL AND CHILD HEALTH THROUGH STATISTICAL STUDIES

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WHILE IN RECENT DECADES maternal and infant mortality rates have dropped dramatically, the downward trend has apparently halted in both infant and maternal mortality. Figures from the National Office of Vital Statistics show that for the Nation as a whole in 1957, for the first time in two decades, the rate of maternal and infant deaths failed to decline. Moreover, the major causes of maternal mortality and their relative proportion as a cause of death has remained the same.[1]

More intensive basic and clinical research as well as continued improvement in obstetric care is clearly indicated if we are to save mothers' lives and make significant headway with such morbid states in children as cerebral palsy, mental retardation, and other conditions associated with damage suffered before, during, or shortly after birth. Epidemiological studies are equally important, sometimes even more so. By pinpointing the location of a health problem, they help us to see not only the nature of problems that still need solving but also where modern knowledge and skills have not penetrated sufficiently to prevent needless tragedies. The effort to locate health problems was in fact one of the main reasons behind the development of vital statistics.

How epidemiological studies can be used to bring about needed improvements in maternal and child health programs may be illustrated by some of our experiences in North Carolina.

In North Carolina the law requiring the reporting of vital statistics, passed in 1913, resulted almost immediately in recognition of the tremendous mortality associated with childbearing. This in turn led to continuous and successive steps toward correction. For example, an early followup of vital statistics records showed that most of the women who had died in child birth had had no prenatal or other medical care and had been delivered by untrained midwives whose ability was suspect even in those days. Such revelations led to the establishment of prenatal clinics and licensing and training of midwives.

Today a number of studies concerned with finding the reasons for maternal and infant deaths are underway which have been initiated and are primarily supported by the North Carolina State Medical Society, with varying degrees of assistance from the North Carolina State Board of Health, the county health departments, local hospitals, and physicians. Others have been initiated by and are largely supported by the State Board of Health, with the support and cooperation of the various branches of organized medicine. Still others have been initiated by local health departments which call upon the State and medical society services as needed.

In 1945 the North Carolina State Medical Society established a committee on maternal welfare to study any problem related to obstetrics and, more specifically, to review all the maternal deaths in the State.[2] The findings of the committee [3, 4] have been widely used for presentation to medical students, medical societies, and, to some extent, lay groups. Another committee of the State medical society, the committee on child health, has been conducting a study of neonatal deaths in hospitals having a hundred or more deliveries each year. This committee has not yet published any of its data, but is preparing to do so in the near future.

In 1954 the State Board of Health initiated a study of perinatal deaths under a grant from the Children's Bureau. This, a continuing study, now is being made in six hospitals, three of them associated with medical schools. Reports on the methods of collecting and analyzing data and on some of the clinical findings [5, 6, 7, 8, 9] have been used in the teaching programs of the State's three medical schools as well as in presentations before local and regional medical groups.

Vital Statistics Services

The State Board of Health provides active assistance to these studies. Its section on vital statistics locates death certificates, performs any necessary cross-matching with birth certificates, and tabulates and prepares data. County health officers and county public health nurses follow up the statistical work by procuring detailed information concerning each maternal death—an activity which has stimulated some county health departments to examine their own maternity and infant programs more carefully.

The section on vital statistics provides two other services, invaluable in helping county health departments and hospitals see where and how they need to bring about improvements. The first and oldest is the issuance of annual reports of the health activities of each county, prepared jointly by the State Board of Health and the county involved. These reports include population data, income data, number of professional people practicing in the county, natality, mortality, and morbidity figures, health department activities, health programs, and other items of interest and importance. If the county utilizes its annual report it can readily evaluate its own health situation and take needed steps for improvement. The section on vital statistics also publishes other, more specialized, annual reports which can be used as supplements.

The other service, now 6 years old, is the annual provision to the hospitals in the State of a summary of the data concerning perinatal mortality in the hospitals. Each hospital is assigned a code number, known only to those handling the data and to the hospital itself, so that the hospital can find its own standing in comparison with the others.

The hospitals, particularly the larger ones, have evinced considerable interest in these reports. Many have requested State consultants, especially the obstetric consultant, to be present at staff discussions of the report. A better response from some of the smaller hospitals can be anticipated as they develop separate clinical departments to which the reports can be transmitted rather than to the hospital superintendent.

A County Study

In spite of the meagerness of facilities and the superabundance of routine work in most of the county health departments in North Carolina, several important studies have come from county health departments, conceived and carried out locally with little or no outside consultation.

One young health officer began a series of projects designed to lower the high infant mortality rate in his county. Finding severe nutritional deficiency among maternity patients, he and his nutrition consultant devised a simple method of scoring diets which they used as an aid in evaluating their ob-

Table 1—REVIEW OF DIET RECORDS, 300 PRENATAL PATIENTS, Halifax County, N.C., June-November 1956

	percent
Diet scores:	
Good	3
Fair	13
Poor	84
Amount of milk:	
3–4 cups daily	4
2 cups daily	7
1 cup daily	16
½ cup daily	2
None	71
Hemoglobin:	
70 percent and over	55
60–69 percent	35
50–59 percent	9
Unknown	1

stetric patients.[10] See table 1. They then secured basic foods from Federal surplus commodities for those patients who had poor obstetric histories or a low dietary score.

Originally the plan called for a control group, but it soon became apparent that this would be impossible to secure. However, the planners went on with the program on the theory that any improvement observed in the mortality rate and in the general condition of the mothers and infants would be convincing evidence of its value. The practical training in nutrition prenatal patients are receiving as a part of this project may be even more important than any immediate benefits from the surplus food provided.

Outcome of Prematurity

The nurse consultant of the State Board of Health's maternal and child health division has been encouraging county health departments to keep a registry of all infant deaths. Following an examination of the death certificates with the matching birth certificates, the county public health nurses interview the mothers, attending physicians, and others, obtaining considerable information not provided by the certificates.

As a result of this procedure, the nursing staff of one county health department initiated a continuing and intensive evaluation of its maternity program including an analysis of neonatal and infant death rates. By matching infant birth and death certificates, the department found that the problem of prematurity was greater than that shown by the usual vital statistics summaries. This led to an interest in the outcome of those premature babies who survived.

In the succeeding 7 months the nurses conducted a survey of school-age children who in infancy had been cared for under the North Carolina State program for premature babies. Of the total of 139 children, 106 were located and seen. The gross preliminary findings on these 106 children were quite startling, even when allowance is made for the fact that because of the demand for bed space the premature infants admitted to the State program were generally smaller than average and from families of low socio-economic status. Only 54 percent of these children were considered to be free of serious defect by their parents, teachers, and the examining nurses. Thirty percent of them presented severe impairment such as cerebral palsy, mental retardation, and major congenital anomalies. The remaining children exhibited a variety of auditory, ocular, and speech defects.

After obtaining this picture the county health department requested consultation from the State on two points: (1) How could the department improve its contact with premature infants after they were discharged from the hospital? (2) Would further followup study on these children be desirable, and, if so, how it could be carried out? The result of the second question was the formulation of plans to subject the children to intensive physical, psychological, and social examinations. A group of children who were comparably premature but had not been in the State program for premature babies, and a group of children who were full-term infants will be selected as control groups.

During the discussions concerning the desirability of such a study, it was pointed out that large-scale and expensive studies of premature infants have been carried out in other parts of the country. However, the decision was to continue with the study because of the value of replication and because of the importance of having specific local information. A local study, it was pointed out, would have more influence with the county commissioners, welfare workers, physicians, and other local people than would data from a medical center elsewhere.

Program Changes

A most successful study from the viewpoint of program planning has been carried out in a large rural county populated by Caucasians, Negroes, and Indians in about equal numbers. This county has over the years had high mortality rates of all kinds, including high infant mortality. Traditionally a large percentage of women have been delivered by midwives, whom the health authorities have had difficulty controlling.[11]

In 1954 the health educator and nurse supervisor of this county's health department began cross-matching infant birth and death certificates. Subsequently, the public health nurses interviewed the mothers or relatives of all the deceased infants and accumulated pertinent information from other sources such as hospitals, attending physicians, and birth records. The interviews were conducted as soon after the death of the infants as possible.

After the first year the information collected was summarized and certain patterns became apparent. Table 2 presents a summary of the infant deaths according to the attendant at delivery, the place of death, and the attendant at death.

Table 2—INFANT MORTALITY ACCORDING TO ATTENDANT AT DELIVERY AND DEATH AND PLACE OF DEATH
Robeson County, N. C., 1954

	attendant at delivery	
	physician	midwife
Number of infant deaths	71	23
Place of death (percent)	100.0	100.0
Home	52.2	95.7
Hospital	47.8	4.3
Attendant at death (percent)	100.0	100.0
None	19.7	74.0
Physician—day of death	26.8	8.7
Physician before day of death	53.5	17.3

The study revealed that the infants of the mothers delivered by midwives had little or no medical care during their terminal illness, and that many of these babies were ill for some time prior to death. Their mothers had had little or no medical care prior to delivery in spite of the fact that medical care was available in the county for all pregnant women, including the indigent, as prenatal clinics were held by the health department on a monthly basis in eight different communities. Many of the families, moreover, could have afforded private medical care.

As a result of these findings, the local health department requested simultaneous consultation from the local physicians and staff members from the State Board of Health. It seemed to these consultants that the local women were simply not oriented to the need for good medical care. After a long meeting the consultants came up with the following conclusions:

1. A centralized maternity clinic which would meet on a weekly basis and would provide the best quality of obstetric care was imperative.

2. Some effort to arrange for many, if not all, of the clinic patients to be delivered in hospitals under proper medical supervision should be made. This would require further consultation with hospital management, the local department of welfare, and the county commissioners.

3. The need for a better followup plan between the hospital and the health department in respect to premature infants was the major pediatric problem, but one that could be solved without too much difficulty.

4. Since infant diarrhea or gastroenteritis was the major cause of infant deaths, changes in feeding techniques appeared to be sorely needed.

5. A well-baby clinic similar to the maternity clinic was sorely needed.

The plan to hold a single maternity clinic in the county health department building instead of the monthly clinics in eight different communities throughout the county brought considerable protest from the profession personnel, as well as the communities where the clinics had been held. Therefore, the centralization was begun slowly by closing down one clinic, but when it was discovered that the patients would go to a central clinic just as readily as to a clinic in their own community, the remainder of the clinics were closed, except for the centralized clinic at the county seat. While coming to the centralized clinic entails considerable travel for some patients, our experience with it has confirmed our conviction that the quality of the service rendered is far more important in the maintenance of clinic attendance than the distance which the patients have to travel. Subsequent experience in other counties has reinforced this belief.

A second consultation in this county, this time including representatives of the county medical society, the hospital, the local welfare department, and the county commissioners, produced some vital results. The physicians, who agreed to rotate through the clinic, were assisted in promoting the hospitalization program, since they were not anxious to provide prenatal care to patients who would be subsequently delivered by midwives. Moreover, there was the possibility, which became a fact, that medical students and a house officer from a medical school might be assigned to the hospital if a sufficient number of patients and adequate supervision were available.

The administrator of the hospital, a nonprofit institution, saw a financial advantage in admitting patients for simple delivery and a short post partum period while they had no complications instead of running the risk of getting them later as seriously ill obstetric patients; he also saw the possibility of collecting a portion of the cost of hospital delivery if the hospital's contact with the patient could be established in the ante partum clinic. The local department of welfare offered to assist, defraying as much of the expense as its financial limitations would permit. The county commissioners suggested the possibility of some financial assistance from the county if the demand did not become too great.

Results

In practice the plan has worked well for the past 2 years. At the doctors' request no patient is admitted to the clinic without a note from her physician, but the doctors have willingly provided such notes to patients who could not afford private care. However, the plan does not completely solve the problem of getting patients to seek early prenatal care, and the public health nurses, health educators, physicians, and others have continued all of their usual activities toward securing earlier medical care for this group. All of the people associated with the clinic feel that the high quality of professional care has helped in getting these patients into the prenatal clinics earlier.

The physicians also take turns making hospital calls on the clinic patients who have been admitted to the hospital. The clinic records are taken to the hospital after each clinic meeting and kept there until the next time the clinic is held, so that prenatal records are always available in the event the patient is admitted to the hospital in the interim. Attempts are made to train the mothers in proper feeding technique before they are discharged from the hospital—an activity not possible when mothers are delivered at home.

While there has been no significant change in the number of new patients admitted to the clinic as compared to the number admitted to the eight clinics previously operated, the average number of prenatal visits per patient has increased from two to five. Hospital deliveries have risen and midwife deliveries have fallen, continuing a trend which had begun even before the inauguration of the program. The perinatal mortality rate, however, has not improved as much as had been hoped, but in the past 2 years, the State as a whole has experienced a slight rise.

Many patients have paid a part of the cost of their hospitalization. Since the amount which they have paid is far below the actual cost, the county commissioners, without any formal agreement, have reimbursed the hospital for the difference. Teaching the students has been a tremendous stimulus to the private physicians participating in the clinic management. Student nurses from the nurses' training school associated with the hospital also attend the prenatal clinics.

In this county the study of maternal and child health problems and designing a program to correct them involved many lay organizations. The wide interest aroused is likely to promote better maternal and child health in the years to come.

In addition to the three specific programs described, other counties have utilized the techniques of matching infant death certificates with the birth certificates, to begin improvements of their maternal and child health programs. This technique is simple and inexpensive and can be utilized by even the smallest health department.

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THE EFFECTS OF PREJUDICE ON CHILDREN

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AN INVENTORY of social research in the area variously called intergroup, intercultural, or race relations pertinent to children would be a prodigious task, for practically all research in this field—most of which deals with adult subjects—has pertinence to children. A herculean effort would be required to do justice to only one phase: synthesizing findings of the voluminous surveys and studies using adults as subjects and assaying their composite significance for the growth and development of children. The relevance of these adult subject studies to children is, in part, immediate and direct; in part, derived or secondary.

Even the small proportion of this type of research which uses children as subjects has reached a formidable size. However, a manageable sample is offered by selection of the two following aspects:

1. Investigations into some of the causal factors and identifiable effects of intergroup prejudice in children.

2. Studies of the effects on children of some types of experience, with special reference to contact with other ethnic groups.

Causal Factors in Prejudice

In using the term "prejudice" I am referring to a set of attitudes which causes, supports, or justifies discrimination—what Arnold Rose has called "the mental state corresponding to the practice of discrimination."[1] A number of studies have found that intergroup prejudice in children makes its appearance at an early age.[1, 2, 3, 4] Findings of these investigations conflict with the "clean slate" view of the young child: that negative "writings" of group consciousness or prejudice do not appear until shortly before or during adolescence.

Among the most dramatic of the findings showing evidence of early prejudice are those of the Philadelphia Early Childhood Project, conducted in the late forties, indicating that "little children, on first coming to school, have the words, and sometimes the feelings, of prejudice."[5]

This project dealt also with the question: What causes the children to be prejudiced? It found that in the children under study prejudices were largely a matter of conforming with the standards and expectations of their social environments. The children learned their prejudices from adults and older children with whom they came in contact. This learning was conveyed through inadvertent example and teaching, as well as through deliberate training.

These findings are supported by other studies and observations, including the early studies of Bruno Lasker,[6] the value-oriented studies of the sociologist David Riesman,[7] the clinical findings of a number of psychiatrists,[8] and the analyses of the sociologist Milton Barron.[9]

Else Frenkel-Brunswik, investigating prejudice in children between the ages of 11 and 16 in Berkeley, Calif., as part of the monumental work, "The Authoritarian Personality," concluded that prejudice was one of a number of attitudes correlating with personality type. She found it to be a significant outgdowth of the child's personality: the more prejudiced child tended to be more rigid, and more conforming to the values of authoritarian figures than the less prejudiced child. Thus, prejudice appeared as a function of the child's basic personality.[10]

The possibility of conflict between the findings of the Philadelphia and Berkeley studies has been the subject of debate. However, a "reconciliation" of the two submits that:

> There is within our society a very wide range offered to the individual between tolerance and prejudice. He may choose any one of a number of positions, or several positions simultaneously or successively, without departing from what is regarded as the cultural norm . . . which social attitudes he will accept as his own depends on personal as well as social factors. And within the "normal" range of prejudice and tolerance, it is probably not easy to distinguish the personality elements from the complicated interplay of social influences.[11]

The Effects of Prejudice

Investigations of the effects of prejudice on children seem almost to flow from the studies of causal factors. Most of these are focused upon children of minority groups.

It has been found that disadvantaged Negro children became aware of race at an earlier age than white children.[12] This awareness includes the low status accorded their own group. It tends to affect negatively the Negro child's perception of himself and his group.[13] The following tendencies have been observed frequently among children who have experienced prejudice:

1. The development of self-hatred—"a social psychological phenomenon, even though it usually influences deeply the total personality.[13]
2. The display of extreme overidentification with a "model" or "hero" within their own ethnic group.
3. The development of aggressive behavior patterns symptomatic of hostility toward society. In addition to individual personality problems, children so affected present a social problem in their susceptibility to becoming links in the negative cycle of prejudice, antisocial response, and reenforcement of group stereotype.
4. A stimulation to higher aspirations than those of their peers in the majority group. The investigator in one study with such findings offers as a possible explanation that "the Negro child on the elementary school level may, of necessity, have better defense mechanisms against defeats and disappointment than his white schoolmate." He surmises further that the Negro child's feelings of insecurity may be the bases for the higher aspirations.[14]

A few of the studies in this area are concerned with the effects of prejudice against minorities on children of the majority group. Here, generally, the investigators identify the processes of acquiring and maintaining prejudice as factors in the child's socialization and character formation. These findings tend to coverge in the conclusion that prejudice against other ethnic groups, built on perception and feeling about ethnic difference, is associated with—in fact, may result in—interference with the healthy growth and development of the child holding the prejudice.[15, 16] Hartley summarizes the personality characteristics of prejudiced young people as: unwillingness to accept responsibility; acceptance of conventional mores; rejection of serious groups; rejection of political interests, desire for groups formed for purely social purposes, and absorption with pleasure activities; conscious conflict between play and work; emotionality rather than rationality; extreme egocentricism; interest in physical activity, the body, health; dislike of agitators, radicals, pessimists; a relative uncreativeness; apparent inability to deal with anxieties except by fleeing from them; and, often, a physical activity which has in it a compulsive component.[17]

A group of 35 eminent social scientists have summarized the results of a wide range of social investigations on the effects on children of prejudice against minority groups, in a document of major social import—an appendix to the appellants' brief to the Supreme Court of the United States in the cases presented against segregation in the public schools. Among the effects on majority group children, they include: learning to "gain personal status in an unrealistic and nonadaptive way" and the development of "guilt feelings, rationalizations, and other mechanisms" which are used in protection from recognition of "the essential injustice of their unrealistic fears and hatreds of minority groups." [18]

Citing a paper prepared for the Technical Committee on Fact Finding of the Midcentury White House Conference on Children and Youth,[19] these scientists also noted the effects on children of discrepancies between adults' admonitions and behavior:

> The report indicates further that confusion, conflict, moral cynicism, and disrespect for authority may arise in majority group children as a consequence of being taught the moral, religious, and democratic principles of the brotherhood of man and the importance of justice and fair play by the same persons and institutions who, in their support of racial segregation and related practices, seem to be acting in a prejudiced and discriminatory manner.[18]

In regard to the learning of prejudice, Allport has noted that "it takes him [the child] the first 6 to 8 years of his life to learn total rejection, and another 6 years or so to modify it" to fit the "complex adult creed" which attempts to combine ethnocentricism with democracy.[15]

Thus the studies in this area tend to support the conclusion that "segregation, prejudices, discriminations, and their social concomitants potentially damage the personalities of all children—the children of the majority group in a somewhat different way than the more obviously damaged children of the minority group." [18]

This damage includes effects on the value systems, standards of beauty and acceptability, symbols, concepts of "good" and "bad."

> For example, several studies carried out in this country [the United States] have indicated that most small children of both groups [Negro and white] preferred light dolls to dark ones, even though there is little or no antagonism discernible toward dark ones.[8]

Another study reports that while the children in a biracial nursery school played together "with the camaraderie of their common developmental concerns" they revealed their awareness of differences and gave evidence of confusing color with values. This study also revealed awareness on the part of the Negro children of confusion and uncertainties on the part of white staff members striving to overcome discriminatory feelings acquired in childhood.[3]

Allport also indicates that the earliest age at which children take any note of differences in skin coloring is two and a half.[16]

Attitude and Behavior Change

Studies which report attempts to modify the prejudices of children are less numerous than those which are descriptive of the child's attitudes. Cross-sectional sampling of investigations into change in behavior and attitudes identifiable as the products of face-to-face contacts with persons of other ethnic background reveals a fairly high incidence of agreement in one regard: contact with other ethnic groups does *not*—of itself and alone—bring about significant change in behavior, or attitude, toward the "other" groups. Rather, the results of these contacts seem to depend upon:

1. The personal security of the individual child within his respective ingroup.
2. The social climate in which the contact takes place.
3. The use made of the opportunity presented by the contact by those in leadership roles.
4. The degree of consistency between the verbal expressions and the behavior—overt and subtle—of the children's adult "models" within the contact situation.

These studies vary widely in sizes and samples, settings, and ages of subjects.

As a child acquires his group membership, he also establishes relatedness with other groups which is crucially mediated through verbal symbols of his own reference groups. These reference groups serve as the main anchorage in determining his perceived relations with his social world.[16]

It can be strikingly demonstrated that in a neighborhood where the mores are those of racial discrimination and strife, the children will behave in a similar fashion, while in a camp setting where there is no significance given to racial differences the same children accept those of other races as being without important differences.[8]

In Great Britain in 1950 a group of 14- to 16-year-old white school children is reported to have shown swift change in attitude toward Negroes—from fear and negative prejudice to acceptance and positive feelings—as the result of having been taught for a period of less than 2 weeks by two Negro teachers from Africa.

In interpreting the results the author stressed the permissive atmosphere in which the contact with the African teachers took place and the friendly and reassuring manner of the teachers which quickly dispersed the initial anxieties displayed by many of the children at the prospect of meeting Negroes.[20]

Other studies and theoretical writings undergird the conclusion that contact with other ethnic groups does *not* alone produce a significant change in the attitudes toward these groups. Prevailing social attitudes and contact with adults whose words may or may not be consistent with their behavior seems to be much more influential in formation of the child's point of view and his patterns of behavior toward minority groups.

Gaps in Research

Unfortunately, few studies are directed toward an evaluation of the effects of intercultural education programs on the child. The Philadelphia Early Childhood Project is an outstanding exception. Trager and Yarrow have demonstrated in this report [2] that democratic attitudes *can* be taught to young children. They reported that the project contributed to "an understanding of some of the important conditions which are conducive to learning attitudes," and concluded: "If democratic attitudes are to be learned, *they must be specifically taught and experienced*."

Finding that discrimination and prejudice are facts of both the social structure and the personality structure, Allport suggests a "pluralistic approach" with remedial programs "of two types: those stressing change in the social structure (e.g., legislation, housing reform, executive fiat), and those stressing change in personal structure (intercultural education, child training, exhortation)." [16]

Reimann comments on the dearth of documented conclusions, based on systematically secured evidence, relative to attitude- and behavior-change of children in intergroup experiences, and adds:

> The subject of children's prejudices is also deficient in another type of study—one that would consider it in a nonlaboratory atmosphere, in the ordinary relations of social life, in terms of *social behavior* (physical and verbal) rather than *verbalization*.[12]

An illustrative situation has been provided by the casual observation of a writer who tells of watching an apparently congenial group of Negro and white children en route to school. As they parted at the corner to proceed to their "separate but equal" schools, the faces of the white children seemed to reflect feelings of "superiority," while those of the Negro children "mirrored subdued acceptance."

Such dramas of daily life, their numerous counterparts, the *behavioral* evidences of their repeated effects upon the children's perceptions of themselves, of each other, and of the "democratic" society which assigns them their respective roles, are amenable to social investigation. More difficult, but also susceptible to the research approach, are systematic attempts to modify these experiences, to bring about positive changes in the children's perceptions, and to apply scientific procedures in followup tests of the effectiveness of such efforts. The present opportunities for such research engagements, in settings in which school or neighborhood desegregation is in motion, probably are unparalleled in the history of social research.

This is not to suggest that no studies within the desegregating locales are in progress. There are many. In New York, for example, thousands of women throughout the city are engaging in an action-research effort to assess the potentialities and problems of a new city ordinance against racial discrimination in private housing. Among the focuses of their attention will be the functions of children in the decisions of minority families to move into neighborhoods never previously accessible to them and of the various age groups in the types and extent of majority-minority interaction in these neighborhoods.

In a consideration of areas for future research, the aggregation of current studies of the desegregation process might be looked at in regard to:

1. The proportion which are purely descriptive.
2. The actual number which dare to predict.
3. The volume directed toward collection and analysis of behavioral as well as verbal data.
4. The incidence of effort to document evaluation of the myriad educational approaches and programs which are being devised to assure success in the change.
5. The incidence of methodologies which take advantage of the presented opportunities for participation of laymen, educators, social action professionals—all of whom are directly affected by the process—in the planning, conduct, interpretation, and evaluation of the research undertaking.

Whither Current Research

This writing must end, as it began, with a reference to a needed herculean effort—this time the one required to locate and inventory current research which is pertinent to the prejudices and discriminatory actions of school-age children. By "current" I mean research proposed, planned, or in progress *now*, which I know is a formidable amount. For example, to take but one minority group, the number of current studies of Puerto Rican children and youth in the United States seems limitless. Following the traditional formulae for studies of minorities, they comprehend investigations of the forces and factors which seem to facilitate or hinder acculturation. They include analyses of patterns of voluntary associations. They cover investigations of pathologies—delinquency, crime, disease, interpersonal and intergroup conflict. They embrace inquiries into the role and functions of community institutions—the school, the church, the character-building agency—in promoting the accommodation of the child to "American" ways. They cover analytical studies of living conditions and patterns of family life among the Puerto Rican "newcomers" to the mainland.

The volume and characteristics of many of these investigations pose questions which have relevance for all research in intergroup relations:

1. Will there be a significant proportion of these studies which provide socially useful data about ordinary relations of social life?

2. Can there be even minimal communication among the many investigators sufficient to provide for systematic replication, where this is feasible, rather than unplanned, possibly wasteful, duplication?

3. Can resources be made available for the synthesis and reconciliation of the many results that must come forth?

4. Will the composite total of the many studies represent a full range of research—basic and applied—which ultimately may push back the frontiers of knowledge about the ways in which all children may be guided more freely toward the goal of true democracy?

The apparent heightened tempo and activity of research in this field can result in seriously unbalanced and deficient findings, unless approaches are broadened. For example, preoccupation with low-economic groups can preclude attention to the sharply rising number of middle-class Negro children—the cultural and economic prototypes of the majority of their white peers. These are the children who are being projected, in increasing incidence, into the "desegregated" situation, the "integrated" setting. Their interactions with children of the dominant social groups present a scene stripped of all variables save those of differences of color and race, thus baring the real functioning of prejudice and discrimination in present-day society.

It becomes incumbent upon social research to embrace in its concern the meaning of the segregated experience, the effects of prejudiced attitudes and discriminatory behavior on the growth and development of all children—of the majority, of the minority, of high, middle, and low status. In a world in which egalitarian concepts are in the ascendancy, it is a social imperative that scientists design instruments for more incisive inquiry, for truly meaningful investigations into the societal conditions which engender and support the training and conditioning of democracy's children.

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> . . . Anyone, regardless of age, who feels no one cares about him is to some extent a lost soul. If adults cannot bear this, how much more difficult it must be for children to take.
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> *Eleanor W. Gordon in* The Child Welfare Worker and Adoption, *New Jersey Department of Institutions and Agencies, June 1958*

ADMINISTRATIVE RESEARCH IN SOCIAL AGENCIES

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A BOARD MEMBER of a voluntary social agency tells how at his fifth meeting he found himself injecting the same questions into the discussion as he had at every other: "What does a case situation like that one just presented cost you?" "How many similar case situations have you had?" "Out of a budget of $______ from the Community Chest and other donations, do you have a way of knowing what the 'input' is?" "Do you know your 'output'?"

This board member, dean of a university graduate school of business, believes that he was raising important questions. At least they were in the context of a businessman's approach to cost analysis and accountability of funds placed in the agency's trust by him and other contributors to private social services.

The agency director, wanting to know how he could arrive at such costs, always responded with the questions: "What is 'input' and 'output' in a social work agency?" "Which items in a line-item budget should be used to determine costs?"

These incidents occurred before the Children's Bureau published the blue paperback book entitled "Cost Analysis in Child Welfare Services."[1] Here at last are accounts of the application of work measurement and cost analysis to a private child-placing agency and to a private children's institution—the first prepared by Edward E. Schwartz and the second by Martin Wolins. Together they represent the first effort of the kind in the child welfare services field, an effort that is not merely an explanation of how such analysis might be done, but a detailed explanation of how it was done.

Public administration approaches to the development and installation of work measurement were adapted to measure "input" in a social service agency, and "end products" or units of work were identified and operationally defined. In the child-placing agency time expended by professional social workers, supervisors, and clerical staff in completing units of work was considered the "input." In the institution, "input" also included time expended by psychologists, houseparents, and others who dealt directly with children. "Output" in both instances was the completion of an identifiable process that resulted in the production of a unit of work or end product, which could be the acceptance or rejection of an application of a child for service or of a foster parent applicant, or the provision of a complete service.

Data obtained from the time records maintained by the staff were reduced to averages or "mean times" for producing a work unit, and then related to dollars to arrive at unit costs. The dollars used differed in each setting. In the child-placing agency, for example, they included salaries of the employees who recorded time, their telephone and travel charges, and expenditures for the maintenance of the children given service.

These two projects were undertaken to develop research methods that would contribute to improving the administration of child welfare agencies. Both reports include detailed accounts of: (1) the procedures used to select appropriate work units; (2) the pretesting of the methods for collecting data; and (3) the analytical processes used to convert the work measurement results to unit costs. Almost any child welfare agency, public or private, can use these studies as guides for developing unit costs of services and use such results for improving administration. No agency can assume that the findings in regard to the agencies studied by either Schwartz or Wolins are applicable to itself without applying the methods described.

The pioneer efforts of Schwartz and Wolins should not be underrated. Someone has had to make such a comprehensive analysis in order to clarify and eliminate many of the imponderables confronting measurement of social work activities in this field. As Schwartz points out, the next steps are simplification of these methods. It is clear that he recognizes that work measurement and cost analysis are only some of the management tools needed by an agency executive to plan, to execute, and to control current plans and to forecast future plans.

Revisions for Use

How may we go about simplifying this approach, which is restricted to the measurement of time expended in providing *direct* services to children? An agency might learn first the proportion of employee time expended in direct services and in facilitating or nondirect services to ascertain what proportion of the working time is chargeable to cases. In the agency he studied, Schwartz learned that the staff spent 27 percent of their working time in nondirect services. Is this too much or too little? Or an agency might introduce the plan described without making any major alterations but limit the study to social work personnel. In the latter case, sampling should be introduced to reduce the volume of data to be analyzed and to assure quicker returns for management use. Both authors indicate that sampling is possible.

These two studies demonstrate the need for developing more than one statistical "mean time" expended in completing a unit of work. The authors suggest a need for differential means: "mean times" for experienced as against beginning social workers; and "mean times" that differentiate among case situations. Both affect the average time expended.

Consideration should also be given to converting mean minutes per work unit to mean hours, but the statistical error of such conversion must be studied. Mean minutes per work unit indicate a precision and accuracy that does not necessarily obtain when time is recorded by the person performing the work. In industry mechanical devices can be used to count minutes, seconds, and fractions thereof with accuracy, an accuracy probably needed to control flow of work and costs of production.

Time records of student caseworkers should be excluded from the analysis because students invest time differently than graduate social workers. The dollar amounts chargeable to "teaching of social work student" would be computed on the basis of time expended by regular agency employees assigned to this activity.

Performance Expectations

To carry out the purposes of these studies, the authors converted minutes expended per work unit to unit costs by using selected dollars of the budget as the numerator. Agencies introducing work measurement may follow the same plan, but at some point should consider the development of performance expectations in terms of the time required to produce a work unit of specified quality. Such performance expectations, as Thomasine Hendricks stated recently, "serve both as a basis for evaluation for the social worker and as a goal toward which he strives."[2] They also serve as an important administrative device in controlling current plans and in forecasting the future if differential expectations are developed, that is, different time requirements for different case situations, for workers of different levels of experience, and the like.

The establishment of such expectations is no easy task and requires careful consideration of the quality level to be maintained.

Studies need to be made to: (1) ascertain how much time is expended; (2) question what particular work unit or units consume the time; and (3) to find out what can or should be done to reduce time expended in processes where they can be reduced without jeopardizing quality.

This approach squarely challenges social workers to begin to use typologies according to some meaningful conceptual framework, such as Wolins used from Maas'[3] work in this field or the classification plan developed in the St. Paul study of multiple-problem families. It also challenges the profession to clarify treatment goals for each child served and to begin to find out what it takes in the way of "input" to reach such goals. This proposal also requires a child welfare agency to consider carefully its philosophy and the practice theory under which it functions. The agency will also have to decide how much of the "parenting responsibilty" it should assume, under what circumstances, and under what conditions.

There are other important considerations about the introduction of work measurement and performance budgeting. How can these devices be introduced so that they will yield the greatest payoff with the minimum expenditure of time on the part of staff recording time and staff engaged in data analysis? What talents are needed to install, analyze, and keep on top of a work measurement system? What should be done to provide data that are timely?

There is no doubt in the minds of many persons that social workers and other employees of a social agency need to be consciously aware of how they utilize their time and to be accountable for the use of time.

Work measurement is a method of accountability, and the results obtained through its use serve as a basis for developing unit costs and performance budgets. These are some of the management aids needed by agency executives to control current resources—manpower and money—and to forecast the volume of those resources needed in a future period.

Installation of work measurement along the lines described by Schwartz and Wolins should help to bring about better communication between agencies and the funding organizations and the business community.

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International Publications

INTERNATIONAL SURVEY OF PROGRAMMES OF SOCIAL DEVELOPMENT. Prepared by the Bureau of Social Affairs, United Nations Secretariat, in cooperation with the International Labour Office; the Food and Agriculture Organization of the United Nations; the United Nations Educational, Scientific, and Cultural Organization; and the World Health Organization. United Nations, New York, 1959. 190 pp. For sale by International Documents Service, Columbia University Press, 2960 Broadway, New York 27. $2.

Second in a series of reports prepared at the request of the U.N. Social and Economic Council to describe measures taken in recent years for improving social conditions in various countries, this survey, issued 4 years after the preceding one, includes international as well as national programs. Besides noting the status of many of the programs described in the 1955 survey, the report discusses, in response to specific requests of the Council, recent trends in community development as a technique for improving the levels of living, particularly in underdeveloped areas; measures for meeting problems of rapid urbanization; and public administration of programs of social development.

Among other subjects included are health; nutrition and home economics; labor, including employment of children and youth; social security and related measures; special programs such as those for the handicapped, for children in foster care or day care, for refugees and migrants, and for control of juvenile delinquency. Trends and changes which have taken place since the previous survey are especially noted.

JOINT FAO/WHO EXPERT COMMITTEE ON NUTRITION, FIFTH REPORT. World Health Organization Technical Report Series No. 149. Palais des Nations, Geneva. 1958. 55 pp. For sale by International Documents Service, Columbia University Press, New York 27. 60 cents.

Among the measures for the benefit of child health recommended in this report are: strengthening the nutrition content of medical education; the development of locally available foods suitable for feeding preschool children; the employment of public health nutritionists in the further development of maternal and child health services.

Other measures advocated are: school feeding as a focus for nutrition education; continued investigation of possible sources of protein-rich food; further study of the relation between systemic parasites and infections and nutritional status.

The report recommends that the Food and Agriculture Organization and the World Health Organization continue to cooperate in the work of the United Nations Scientific Committee on the Effects of Atomic Radiation, with respect to the relation of calcium intake and the absorption of strontium 90 into the body.

YOUTH AT WORK; the ILO and youth. International Labour Organization, Geneva. 1958. 47 pp. Copies available without charge from International Labour Office, 917 15th Street N.W., Washington 5, D.C.

Focusing on the ILO's activities in regard to youth, this pamphlet presents the Organization's labor standards for young persons as established in its conventions and describes the ways in which the ILO helps governments meet the labor problems of their young people. The provisions of the conventions outlined concern the minimum age for beginning work; employment of school children; exemptions for children taking vocational training and for those in family undertakings; ages for admission to hazardous employment; medical examination to determine fitness for employment; vocational guidance and training; measures for the unemployed; nightwork; and safety and health.

BOOK NOTES

THE MENTALLY RETARDED IN SOCIETY. Stanley Powell Davies, with the collaboration of Katharine G. Ecob. Columbia University Press, New York. 1959. 248 pp. $5.50.

This book presents a picture of the growth of public and scientific understanding of mental retardation from Itard's work to the present day. A revision of an earlier work by Dr. Davies, *Social Control of the Mentally Deficient*, published in 1930, it incorporates much new material reporting on the changes in thinking, attitudes, and programs during the past 25 years.

The authors show how increasing understanding of mental retardation has led to changes in programs over the years both in the institutions and in the provision and utilization of community resources. The authors conclude by outlining a number of essential features of an overall program for the mentally retarded.

Dr. Davies, a social worker, was formerly general director of the Community Service Society in New York City. Miss Ecob, a psychologist, was formerly executive secretary of the New York State Committee on Mental Hygiene.

EMOTIONAL PROBLEMS OF CHILDHOOD. Edited by Samuel Liebman. J. B. Lippincott Co., Philadelphia. 1958. 176 pp. $5.

Fourth in a series of volumes directed to the general medical practitioner on the handling of emotional problems encountered in his everyday practice, this book includes 10 papers on such subjects as the mother's and the father's role in parenthood; feeding, sleep, and motility patterns in infants; speech disorders; problems of children's and of adolescents' behavior; the character structure of the juvenile delinquent; and emotional problems of children with a severe physical handicap—this last written by an orthopedic surgeon who presents case material to back his contention that the orthopedic surgeon has psychological and social as well as surgical functions. Among the other disciplines represented by the authors are psychiatry, psychoanalysis, and psychology. The editor is medical director of the North Shore Hospital, Winnetka, Ill., and clinical assistant professor of psychiatry, University of Illinois College of Medicine.

A HISTORY OF PUBLIC HEALTH. George Rosen. MD Monographs on Medical History, No. 1. MD Publications, New York. 1958. 551 pp. $5.75.

The story of community health action from its beginnings in the earliest civilizations to its present state of development in the economically and technologically advanced countries of the world is told in this book, addressed to laymen as well as to professional health workers.

The author considers the years 1750–1830 a pivotal period in the evolution of public health, for in those years of upheaval in Europe, he says, the foundation was laid for the sanitary movement of the 19th century. Then, showing how 19th century efforts to halt rising death rates in English cities led to public health developments in the United States, the author notes that at the end of that century came the great discoveries in bacteriology and immunology, which have exercised the most profound influence on community health action ever since.

The author is professor of health education, School of Public Health and Administrative Medicine, Columbia University, and editor of the *American Journal of Public Health.*

UP FROM PUERTO RICO. Elena Padilla. Columbia University Press, New York. 1958. 317 pp. $5.

Puerto Rican families living in a slum neighborhood in New York City comprising 12 city blocks are described in this book by an anthropologist, who studied the people for a year and a half with the help of a sociologist, an educator, and a number of graduate students of anthropology. The book notes especially those cultural differences that affect the recent migrant's adjustment to his new life.

Chapters on "Family and Kinship" and "Growing Up" note the effects of the cultural conflicts within the family, child-rearing practices, the neighborhood, and the school on the lives of children. The author concludes that the changes that the Puerto Rican families undergo in New York are in the direction of the culture of the American slum, "which, although different from the culture of the middle classes, is still American." Other chapters discuss the meaning to these families of accepting public relief and of the prevailing attitudes toward them of the non-Puerto Ricans with whom they come in contact, their attitudes toward health and sickness, the social attitudes within their own group.

EARLY EDUCATION OF THE MENTALLY RETARDED. Samuel A. Kirk. University of Illinois Press, Urbana. 1958. 216 pp. $6.

In this book the author reports on his experiment to determine the effects of preschool education on the social and mental development of young educable mentally handicapped children. The book includes a presentation of the design of the experiment, case studies, and a statistical summary of the results, and describes the diffculties in carrying out this kind of longitudinal study.

In general, the findings suggest that preschool education may have a favorable effect in modifying the developmental picture in some retarded children. According to the author, the evidence indicates that under optimum educational and home conditions preschool education appears to be most effective in this regard with children whose retardation stems from cultural deprivation or a combination of cultural deprivation and organic impairment, and least effective with those with organic pathologies uncomplicated by other factors. He also interprets a portion of his data as indicating that in regard to children from psychosocially deprived homes the greater the changes made in the environment the greater the upward changes in rate of mental growth, and that retarded children who remain in such homes and who do not attend school tend to remain at the same rate of growth or to drop to a lower level.

HERE AND THERE

About Polio

More than twice as many cases of paralytic poliomyelitis have been reported in the United States during the first 32 weeks of 1959 (1,839) as during the corresponding period last year (784), according to the Surgeon General of the Public Health Service, who is urging communities to conduct "block by block and face to face" drives to reach the unvaccinated, the majority of whom live in low-rent neighborhoods.

The great majority of the cases of paralytic polio reported last year were among persons who had not been fully vaccinated against the disease, the Surgeon General points out, adding that in this country at least 50 million persons under 40 years of age—the high risk group—have not been so vaccinated.

Continuing studies made by the Service with local health authorities in many parts of the country show that although cases of paralytic polio have occurred in persons who have been fully vaccinated against it, the probability of contracting it is reduced by 75 percent by vaccination.

Inquiry into 284 of this year's paralytic cases has revealed that only 41 of the persons involved had been fully vaccinated, including only 8 of the 103 children under 5.

A committee of advisers to the Surgeon General that has been reviewing experience with the Salk vaccine recently recommended that infants as young as 2 months of age be vaccinated, and noted that for infants and young children the vaccine may be given either in separate injections or with vaccines for diphtheria, pertussis. and tetanus.

Live Virus

Another Public Health Service advisory committee is evaluating the data presented at the International Conference on Live Poliovirus Vaccines. The conference, which was attended by 61 scientists from 17 countries, was held at Washington, June 22–26, under sponsorship of the Pan American Health Organization and the World Health Organization, with financial assistance from the Sister Elizabeth Kenny Foundation. The committee's findings will be released when received.

Problems concerning the safety and and effectiveness of experimental live attenuated poliovirus vaccines were the main concern of the conference, according to its summary report, which notes that the solution of many of these problems remains to be found. In the report, the scientists recognized the value of the inactivated (Salk) vaccine and strongly urged the continuation of its widespread use, but pointed to the need for a vaccine that may be of lower cost, simpler to use, and capable of having a greater protective effect on a community basis, The report cites studies involving the oral administration of live vaccine to thousands of persons in Africa, Asia, Europe, and Latin America, and two trials involving several millions in the U.S.S.R. No evidence of lack of effectiveness or lack of safety has been adduced, it says.

Minnesota Study

A live virus study is now being conducted by the Minnesota Department of Health as a followup to a project that it carried out in 1958. In that project. which involved more than 500 parents and children (148 families), capsules containing a modified live poliovirus were given to half the group; the other half, serving as controls, received blank capsules. The persons receiving the virus were given three capsules, singly, at 3-week intervals; each capsule contained a virus planned to enable the person to develop antibodies against a different type of polio. Previously, routine blood specimens were taken to check for polio antibodies already present.

Among the persons who received the virus, the department reports that all but 50 developed antibodies and that no unfavorable side reactions occurred.

In this year's followup project, 160 persons in whom antibodies to all three types of poliovirus were detected last year are being retested to determine the present level of antibodies.

At the same time the State department of health is conducting a study among another group of families to compare the effectiveness of a single dose of a liquid vaccine that combines the virus of all three types of polio with that of separate doses of three different liquids, each containing a different type of virus. The comparison involves 65 families—about 230 persons. The new liquid contains a larger dose of the vaccine than was given in the capsules.

In addition, the 50 persons in whom no antibodies were detected after having received capsules last year have been given a single dose of the new trivalent vaccine to determine whether this larger dose stimulates an antibody response in them.

—**Sarah L. Doran**

Homemaker Services

About 150 persons from 11 Western European countries, the United States, and Canada attended the International Conference on Homemaker Services, which met for 3 days in May at Wandschoten, Zeist, the Netherlands. Representing both governmental and voluntary organizations in the health, welfare, and related fields, they included doctors, nurses, social workers, clergymen, and labor leaders. Before closing they organized the International Council of Home Help Services, with headquarters in Utrecht.

Both similarities and differences were reported in the ways homemaker services are provided in various countries and in points of view on how they should be provided. But the participants agreed than an increased need for such services is being brought about by such social factors as population movement, longer life, and the employment of women.

There was general agreement too that the purpose of homemaker services was "to safeguard, protect, stabilize, unify, and reinforce family life."

There was also considerable emphasis on the place of homemaker service in the community as part of a wide range of social and health activities adapted to the community's special needs and involving the cooperation of members of the various professions. With but few exceptions the participants agreed that the number of homemakers now available is inadequate to meet needs.

The need for training and supervising homemakers was also a recurring note, although these concepts were obviously differently conceived.

Repeated reference was also made to the responsibility of government for homemaker service, but there was marked difference of opinion on what this responsibility should be or how it should be carried out.

Differences in viewpoints were most apparent in regard to the division of responsibility between governmental and voluntary agencies, and the function of each in homemaker service. These differences involved basic concepts of responsibility for public welfare in general, the question of whether a government should provide a direct service program or payments to voluntary agencies for home help services, and the relative ability of each type of auspice to provide a flexible service of high quality. They also involved such questions as whether or not a government has responsibility for standards for training, qualifications of workers, and personnel practices when government funds are used.

Exchange of experience also revealed differences in practices in the various countries—particularly in respect to the age of women selected for training or employment, the length of time the service is available to a family, and methods of training. A number of participants reported that their countries have special residential training schools for homemakers, where theory and practice are correlated.

Discussions of what the homemaker does brought out many questions, with answers varying according to opinion and practice. Is the homemaker's function simply to keep the home running smoothly, or does she try directly or indirectly to influence the family life? What degree of responsibility does she carry? What kind of service does she give to a sick person?

Suggestions for improving homemaker programs included establishing refresher courses in homemaking, holding more meetings for homemakers, regulating their working conditions, providing pensions and sickness and accident insurance, controlling working hours, raising salaries, and according status to homemaker service as a career.

The conferees adjourned with the general understanding that a series of similar conferences would be held in the future, the first perhaps 4 years from now.

—Maud Morlock

Facts on Illegitimacy

"The vast majority of illegitimate children *do not* become in any sense a burden to society."

So reported a technical committee which spent last winter inquiring into the facts about illegitimacy in North Carolina. The committee, charged with this investigative task by the North Carolina Conference for Social Service, gathered together data on the incidence of births out of wedlock in the State, what happens to children so born, the extent to which they become public charges, and their eventual "outcome" as adults, and interpreted its findings in the light of social and cultural conditions in the State and the Nation.

While the committee found evidence of a rise in illegitimate births in the State over the past decade, it also found that only 9 percent of all children under 18 years of age who were born out of wedlock were receiving public aid through the Aid to Dependent Children program; only 0.6 percent resided in children's institutions, including training schools; and only 0.4 percent were in foster care.

The costs to the public in 1958 for the care of children born out of wedlock, the committee estimated, were: in the Aid to Dependent Children program, $2,878,200 as against $13,726,800 for other children; in institutions of all types, $1,437,300 as against $13,337,300 for other children; in foster care, $327,000 as against $873,000 for others.

In noting the reported 10-year upward trend in illegitimacy, the committee pointed out that this may be partially due to improvements in reporting. It is also warned that statistics on illegitimate births are "less than perfect" because of reporting delays in remote rural areas as well as efforts to conceal illegitimacy on the part of many women. With these precautions it presented figures showing that 9.1 percent of all live births in the State in 1957 were births out of wedlock—2.1 percent of all the births among whites and 23 percent of those among nonwhites—and that nearly 50 percent of the total were born to mothers under 20 years of age as compared to only 15 percent of the babies born in marriage. The proportion of births out of wedlock to all births were higher for both whites and nonwhites among mothers under 20 than among women above this age.

The higher rate of illegitimacy among Negroes, the committee pointed out, occurred chiefly among the very lowest economic groups. It attributes this in part to a tradition of mother- and grandmother-centered families derived from the days of slavery when marriage was discouraged, in part to the inability of fathers having little economic opportunity to support families, and in part to disorganization among families which have moved from rural to urban areas.

The proportion of children receiving public assistance through the Aid to Dependent Children program among the nonwhite children born out of wedlock (8.8 percent) was only slightly higher than the proportion of nonwhite children born in wedlock receiving such aid (6.8 percent), the committee found, a fact it attributed to the generally low economic status of the group. On the other hand, it found that 9.3 percent of the white children born out of wedlock were on the Aid to Dependent Children rolls as against the 2.5 percent of the white children born in wedlock included in the program.

"There is no reason to believe that punitive measures will serve to reduce illegitimacy," the committee reported. It placed its "best hope" in efforts to improve family life and to bring social satisfactions, training in moral standards, and sex education to adolescents.

The committee's mimeographed report, "The Problem of Births Out of Wedlock; a preliminary report," is available for 25 cents from the North Carolina Conference for Social Service, Post Office Box 532, Raleigh.

White House Conference

By the beginning of September many States had set dates for "Little White House Conferences" to prepare for the Washington meetings of the Golden Anniversary White House Conference on Children and Youth, which will take place March 27–April 2, 1960.

Preparation in the States for the 1960 conference is occurring in various patterns.

In California, for example, the Governor has appealed directly to the citizens of the State to gather in town meetings to plan for Conference preparation; 300 such meetings have been scheduled, each of which will submit recommendations to the Governor by October 1.

Michigan's 73 counties have taken part in 11 regional meetings, attended by several thousand persons, each meeting marking the culmination of a yearlong stocktaking of services for children and youth in the counties included. Each region is reporting on its study projects to the State committee, which in turn will report to the White House Conference. Region 9, for example, including nine counties, has reported a survey in which more than 500 children 9–13 years of age, more than 1,000 high school and college students, and a number of parents gave their opinions on such matters as careers for young people, citizenship, responsibility, use of leisure time, and parent-child relationships.

All 39 counties in the State of Washington are represented on 13 White House Conference regional committees, each of which has 100 or more members. The committees are divided into subcommittees, each concerned with a specific subject, such as economic opportunities for young people, education, family living, courts for juveniles, cultural and environmental influences, recreational opportunities, spiritual resources, and health.

New York has completed nine regional workshops on various subjects, including physical and mental health, education, child welfare, corrective and protective care, recreation, and youth employment. Each subject was discussed by a group limited to 40 participants.

Safety

By mid-August, 66 deaths of children under 3 years of age had been reported since January 1 as due to suffocation by thin plastic film of the type used for garment bags by dry-cleaning establishments.

The Public Health Service has made an intensive investigation of 10 of the deaths, confirming the suspicion that the plastic film, polyethylene, was the causative agent. The investigation showed that only 1 of the 10 children had pulled a garment bag made of this material over his head. Six had been suffocated by plastic garment bags used as mattress covers, pillowcases, or blanket protectors. Two, 5 months and 10 months old, had pulled to their faces plastic bags that had been placed near their cribs. The study, which included six autopsies, revealed no evidence of respiratory infection which is sometimes the cause reported as mechanical suffocation. One death, not followed by autopsy, was of a child placed on a couch covered by a thicker plastic.

The Public Health Service has alerted all State health departments on the dangers of misusing such material, and has joined in preparing an educational folder, "Plastic Film; correct use and misuse—helpful hints to parents," which is distributed by the Society of the Plastics Industry, 250 Park Avenue, New York 17, N.Y. Others cooperating in preparation of the folder were the American Academy of Pediatrics, American Association of General Practice, National Institute of Drycleaning, and National Safety Council.

Those agencies, along with the Federation of Women's Clubs, are also uniting in an educational campaign urging parents to destroy the bags.

A special notice to parents, warning against the misuse of such bags, is being inserted by the Government Printing Office in all sales copies of the Children's Bureau popular publications "Infant Care" and "Your Child From One to Six." Congressmen who distribute "Infant Care" are also being asked to insert the notice.

Refugee Year

July 1 was the beginning of World Refugee Year, a period during which 59 nations are pledged through a resolution of the United Nations General Assembly to take action to ease the plight of refugees living in displaced persons camps or other unsettled conditions in Europe, the Middle East, North Africa, and Hong Kong. When the designated period began, steps toward participation had already been taken in 55 countries, usually through the organization of a national committee.

The purpose is to help the 2½ million refugees who do not have rights equal to those of the citizens of the countries in which they have found asylum to become accepted members of permanent communities, either through resettlement, integration into the life of the country in which they now reside, or voluntary repatriation. One of the goals is to induce host countries to widen their selection criteria so as to accept not only a fair share of all refugees, but also a reasonable proportion of those who are more difficult to resettle.

In the United States the President has designated the United States Committee for Refugees, a citizens' group formed last January, to advise on this country's participation in these efforts. The committee has proposed a program involving additional Federal outlays of funds and surplus commodities for refugee relief, relaxed immigration restrictions, and stepped-up fund-raising campaigns by voluntary agencies to secure at least $20 million for refugee relief.

According to the committee's estimate, the refugees most directly in need of help include 125,000 persons from behind the Iron Curtain now in Western Europe—25,000 of them living in refugee camps; 1,150,000 Chinese in Hong Kong; 1 million Palestinian Arabs in Jordan, Lebanon, and the United Arab Republic; 230,000 Algerians in Tunisia and Morocco; 8,500 European refugees still in China; 5,000 Tibetans in India; and 80,000 persons of various origins scattered through various areas.

About one-third of all the refugees are estimated to be children, most of them living with their own families. There are some orphans and homeless children, however, especially in overcrowded Hong Kong, where thousands of children are reported as roaming the streets seeking food, while 80,000 new refugees enter the city each year.

About half the Arab refugees in the Middle East are children—about 25,000 births occurring each year among this group. Half the Algerian refugees in Tunisia and Morocco are also said to be children—one-eighth of the total under 3 years old.

About one-fourth of the 25,000 refugees still in camps in Europe are children under 16.

Child Welfare

The proposed United Nations Declaration of the Rights of the Child, developed by the U.N. Social Commission several years ago, will be brought before the General Assembly for the first time at the meeting which begins in New York on September 15, 1959. The document was referred to the Assembly by the Economic and Social Council which considered it at its meeting in Geneva in July of this year. It was referred to the Council last spring by the Commission on Human Rights.

. . .

Mothers of young children on the Aid to Dependent Children rolls in Greenwich, Conn., will be helped to "get out of the house" for a few hours a week this fall and winter and at the same time to improve their homemaking skills through cash scholarships for daytime YWCA classes in cooking, sewing, interior decorating, and the like. The scholarships, which include the cost of nursery care for the children while the mother is attending classes, have been made possible by a donation to the local welfare department by a local women's club.

. . .

In an effort to find ways of encouraging unmarried mothers to obtain social services and medical care early in pregnancy, a research and demonstration project has been begun in New York City by the Community Council of Greater New York, with a grant of $39,945 from the State department of social welfare out of Children's Bureau child welfare services funds.

The program will have two stages: (1) efforts to learn why many unmarried pregnant women receive little social or medical service until delivery time; and (2) devising "reaching out" techniques for helping women accept public and voluntary services that are now available to them, and for adapting and extending those services and establishing new ones as needed.

The city departments of health, welfare, and hospitals are cooperating with the council in carrying on the project. An advisory committee includes representatives of the three departments and of voluntary hospitals, social agencies serving unmarried mothers, the State department of social welfare, and the Children's Bureau, Department of Health, Education, and Welfare.

Reasons for the mothers' not receiving services are being sought through interviews held with the mothers at the hospitals shortly after the births, a phase of the project which is to take one year. The advisory committee will then use the findings in devising the reaching-out techniques which will be tried in different parts of the city, especially those in which the out-of-wedlock birth rate is high.

Guides and Reports

SELECTED REFERENCES AND ANNOTATIONS; a tool for interpretation. Ethel Cohen. Prepared for the Committee on Interpretation, Medical Social Work Section, National Association of Social Workers, 95 Madison Avenue, New York 16. 1959. 69 pp. $1.

An annotated bibliography of books and articles on social work, especially as related to practice in health settings, prepared for the use of social workers in professional interpretation to their colleagues of various disciplines.

THE USE OF CASE AIDES IN CASEWORK AGENCIES. National Social Welfare Assembly, 345 East 46th Street, New York 17, N.Y. 1959. 33 pp. 35 cents. Quantity rates on request.

A group of papers describing various experiments in using case aides, not fully trained as social workers, to complement professional staff.

ADOPTION OF CHILDREN. American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Ill. 1959. 60 pp. $1.

A guide for pediatricians in working with representatives of other fields to safeguard the welfare of the adopted child, his natural parents, and his adopted parents; including a chapter on interstate and intercountry adoptions.

URBAN SPRAWL AND HEALTH; report of the 1958 National Health Forum. The National Health Council, 1790 Broadway, New York 19. 1959. 228 pp. $1.75.

A summary of discussions that took place at a 3-day meeting of more than 60 leaders in city and regional planning, public administration, and public health, which was conducted by the National Health Council at Philadelphia in March 1958, analyzing the health implications of the complex problems involved in urban sprawl in relation to their impact on private medical practice, local health departments, community planning for hospital services, environmental and industrial health, mental and social health, and voluntary health agencies.

THE CHILD WELFARE WORKER AND ADOPTION. Eleanor W. Gordon. New Jersey Department of Institutions and Agencies, Board of Child Welfare, Trenton. 1958. 48 pp. Limited number of free copies available on request from the Board.

Some principles for working with children, foster parents, and adoptive parents in placing children for adoption, written in nontechnical language for the consumption of both trained and untrained social work staff.

EDUCATION FOR SOCIAL WORK; proceedings of sixth annual program meeting, Council on Social Work Education, Detroit, Mich., January 29–Feb. 1, 1958. The Council, 345 West 46th Street, New York 17, N. Y. 1958. 124 pp. $3.

Includes papers reflecting the meeting's emphasis on two basic professional educational issues: (1) social-work education and its relationship to other professional education; (2) the objectives and content of the social-work curriculum.

EFFECTS OF A SEVERELY MENTALLY RETARDED CHILD ON FAMILY INTEGRATION, Bernard Farber. Monographs of the Society for Research in Child Development, Vol. 24, Serial No. 71, No. 2. Child Development Publications, Purdue University, Lafayette, Ind. 1959. 112 pp. $3.

Report of a study made in Chicago of 240 Caucasian families similar in socioeconomic status and having a child aged 16 or under with an IQ less than 50, at home or in an institution. The study considers the effects of various factors on family decisions regarding institutionalization of the retarded child; the child's age, sex, and degree of dependence; the presence of normal siblings; and the socioeconomic status and religion of the family.

IN THE JOURNALS

Understanding Families

Because of individual differences in children, there can be no single conception of what constitutes a perfect mother, maintains Gardner Murphy, director of research for the Menninger Foundation, in *Social Casework* for July 1959. ("New Knowledge about Family Dynamics.") Reviewing contributions of the various social sciences—cultural anthropology, psychoanalysis, sociology—to an understanding of the family, he also stresses the value of individualized studies of families in pointing up the differences between families and within families.

We learn from cultural anthropology, Dr. Murphy says, that families often reflect changes taking place in distant parts of the world, absorb and adapt them, and form a new pattern that may lead to widespread changes in family life. Psychoanalysis, he says, has revealed how irreconcilable conflicts in the home give rise to conflicts in social groups as persons relive their old sense of frustration and ways of avoiding pain. Sociology has strongly supported this conception of the unconscious influence of family relationships in helping to develop the whole modern conception of the psychology of social roles, he points out. Studies of individual families, on the other hand, he says, show that differences in individual temperaments, often occurring within families, make it impossible to expect a standard of role behavior—as of a mother toward a child. He adds that families may behave differently at different times according to what is going on at different phases in the parents' and the children's development.

Therapy in Training Schools

Problems faced by correctional institutions that are incorporating treatment practices into their programs are discussed in the June issue of the quarterly, *Social Service Review*, by Robert Vinter and Morris Janowitz, codirectors of a research project that will compare the type and extent of such practices in six institutions. ("Effective Institutions for Juvenile Delinquents: a Research Statement.")

While noting that most training schools today include some treatment efforts to achieve personality changes within their charges and expressing the belief that custody and treatment are not incompatible, they describe three "misconceptions" which block success: (1) the expectation that the correctional agency by itself can resolve the personal and social problems posed by delinquency; (2) the failure to take into account the social dynamics of delinquency; and (3) the reliance on processes "that ideally take place in the two-person psychotherapeutic system" rather than modifying them to "conform to the nature of delinquency on the one hand, and to the reality of institutional life, on the other."

Typically, the authors say, therapeutic practices are introduced piecemeal into an institution program and as a result problems arise from the effects on a number of human relationships—between the juveniles themselves, between the staff and the juveniles, between treatment personnel and other staff members, between the institution and the people of the community, and between the institution and the State department that controls it.

The authors describe their own study as designed to "throw light on the organizational arrangements and processes necessary to incorporate skilled personnel into existing organizations."

Findings on Foster Care

The first of a series of papers reporting on the Child Welfare League of America study of foster care, written by the study director, appears in the July 1959 issue of *Child Welfare*. ("Highlights of the Foster Care Project; Introduction," by Henry L. Maas.)

During the 2-year project, 60 child-placing agencies in 9 communities provided information on 882 children selected at random from a total of 4,281 whom the agencies had placed in foster-family homes, adoptive homes, or institutions. The communities, in various parts of the United States, included rural areas, small cities, and metropolitan areas, and varied widely in socioeconomic conditions.

Among the findings the article reports are:

1. Foster care seemed likely to be a continuing long-term affair for at least half the children who had been in such care for a minimum of 3 months, since they were unwanted at home and had some barrier to adoption.

2. In each community at least 40 to 50 percent of the children in foster care showed symptoms of maladjustment; the emotional disturbance was related not to the length of time the child was in foster care, but to the number of times he had been placed.

3. The percentage of children in foster-family homes, in adoptive homes, and in institutions varied widely from community to community. In order to understand these differences, it was necessary to know community dynamics of a kind not usually considered in giving services.

4. Nearly half of all the children in adoptive homes either belonged to a minority group, or were to some degree physically or mentally handicapped. Only 17 percent, however, were over the age of 2, although 40 percent of the adoptive parent applicants had expressed some willingness to adopt a child over 2.

For Unmarried Mothers

In the *Connecticut Health Bulletin* for July 1959, Alberta M. deRongé, medical social consultant for the Connecticut State Department of Health, describes the expansion of the State's comprehensive program for medical and social care of unmarried mothers and their babies which began in 1956 as a 2-year demonstration in three rural counties. ("Services to Unmarried Mothers and Their Babies: the Role of a State Health Department.") (See "Medical and Social Care for Unmarried Mothers," by Hester B. Curtis and Alberta deRongé, CHILDREN, September–October 1957, for a description of the original project.)

Mrs. deRongé's article shows how the program has since been introduced in various types of communities. For example, in a small city and in rural areas, which have no children's agency and no medical social workers, members of the State health department staff took the initiative in helping local doctors and nurses to understand the needs of the unmarried mother and her baby and to see what could be done to help them. In a larger city, on the other hand, responsibility for stimulating the program was accepted by the local health director, the social agencies, and the community council.

Among the steps taken directly by the State project staff was holding a meeting with members of the State department of education to discuss how local schools can help with unmarried mothers' problems.

Promotion of public health nursing services to the unmarried mother has been part of all the program's activities, says the author, and she states her belief that through the many interdisciplinary discussions that have taken place, social workers and physicians have gained a clearer understanding of the contribution of the public health nurse not only to the work for unmarried mothers but also in all areas of maternal and child health.

READERS' EXCHANGE

WRIGHT: *A youth's opinion*

Nearly every individual or group activity that teenagers undertake could be classified under the heading community-youth participation. Yet this term has come to mean something special enough in the 9 years since the Midcentury White House Conference on Children and Youth that young people attending a National Social Welfare Assembly consultation could conclude that "only a small percentage of youth are participating in community affairs." Mrs. Wright, too, seemed to be using a limited meaning of the term in her article ["Youth Participation in Community Affairs," by Sara-Alyce P. Wright, CHILDREN, July–August 1959], although she did not spell it out. Perhaps a definition we often use in Wisconsin would be helpful to others.

We feel that youth participation exists when one or more of these conditions prevails:

1. Youth sponsor and develop, on their own initiative, projects which affect the *total* community.
2. Youth work with adults in appropriate community organizations.
3. A communitywide youth representative body actively functions for the purpose of exchanging ideas, discussing common problems, and developing and implementing plans for joint action.

Belonging to a club, holding a part-time job, or attending a conference, however, is not necessarily synonymous with participating in community affairs. Action, preferably in cooperation with adults, that helps young people acquire practical and realistic experience for intelligent American citizenship is essential.

I would like to reemphasize Mrs. Wright's stress on the need for capable, understanding, adult support. Of too many communities can it be said that adults do more *for* their youth than *with* them. The *you* in *youth* is often used as a cliche to emphasize the role of the individual youth. I feel that you the adult are just as important if not more so to the future of successful youth participation in our communities.

Phil Bandt
Student, University of Wisconsin, Secretary - Treasurer, Wisconsin Committee on Children and Youth, Madison, Wis.

CRAIG: *Interstaff communication*

I agree with Leita Craig that the "cottage committee" approach ["Reaching Delinquents Through Cottage Committees," by Leita P. Craig, CHILDREN, July–August 1959] is the most practical solution to the ever-present institutional problem of interdisciplinary intercommunication and decision making. It has been my experience that the primary benefit to be derived from this approach is increased psychological understanding and concomitant attitude changes in nonclinically trained living-unit personnel as a result of sharing mutual problems with clinically trained staff.

I should like to emphasize the importance of frequent meetings involving active participation of *all* personnel who are crucial members of the institutional treatment process, which certainly would include every cottage worker who is in daily contact with the boy, as well as the therapist, and, in most cases, the teacher. I am well aware that it is extremely difficult to include all these staff members in frequent meetings because of the obstacles presented by institutional schedules and routines and the resistance encountered in individuals; but omission of *any* key treatment personnel will all too often result in a breakdown of communication and disruption of the treatment process.

Eugene S. Jones
Clinical Psychologist, Fricot Ranch School for Boys, California Youth Authority, San Andreas, Calif.

No substitute for good staff

Mrs. Craig appears to be convinced of the high success of the cottage committee system at the Boys Industrial School in Topeka, Kans. Successful programs merit support but should be subject to constant critical evaluation. Cottage committees with numerous variations have been used in State training schools for many years with varying degrees of success and failure.

The thread of a management-treatment dichotomy seems to run throughout Mrs. Craig's article. This division is emphasized by such statements as: "The role of the child-care worker is to represent management." In my humble opinion, all members of the committee must represent management in order to carry on an effective treatment program.

Committee meetings may easily become expensive, time-consuming periods of "goldbricking" by employees who engage in interminable discussions. Child-care workers (and professionals) may verbalize understandings not possessed. Might better results be obtained if the committee members devoted their time and energies to developing significant relationships with their charges and then made their recommendations to their supervisors? Clinical findings and the youngsters' institution progress would then be evaluated by one small committee of "top echelon" supervisors. It would be expected that broader and deeper interpretations would result. Less bias and inconsistency would be present and more decisive action taken.

Moreover, committees, like individuals, may be "conned" by the institution-wise manipulator. A youngster may be skilled at "pressuring" the committee before it meets by approaching the individual members. Too frequently the "pressure merchants" are the ones who consume the bulk of the committee's time and who are scarcely reached by appearance before the group. These are commonly the ones who please committee members by their seemingly warm and instantaneous responses.

The committee system is no substitute for good staff. Its effectiveness fluctuates in relation to the quality of the participants. Inexperienced, immature, and sometimes disturbed training school personnel only share and spread their immaturity and disturbance. Experienced, mature, and well-adjusted personnel do good work regardless of the operations' structure. Talking together in committees is, at best, a poor substitute for living and working together where communication follows naturally as a result of mutual respect.

Amos E. Reed
Superintendent, MacLaren School for Boys, Woodburn, Oreg.

CHWAST: *Flexibility not overactivity*

Dr. Brickman's reactions to my recent article, "Value Conflicts in Treating Delinquents," in the May–June 1959 issue of CHILDREN, generally strike a very responsive chord although I feel a little uneasy about what he calls the "social unconscious." [See CHILDREN, July–August 1959, p. 160.] My feeling is based on the potential misapplication of this concept as an explanatory principle with a surrounding mystique. Concepts of this type, unfortunately, have a tendency to escape their controlled use in scientific speculation into popular mythology.

Another point which troubles me more, however, is that I might seem to suggest "frenetic overactivity on the therapist's part." Reaching out as an antidote to underreaching need not become overreaching. I would most surely share with Dr. Brickmann a repugnance for crude interventions and manipulations parading as therapy. I would equally deplore noninterventions when the net effect would be to lose the delinquent to treatment.

The delinquent is almost the paradigmatical "unwilling, unable, and unaware" "patient," "client," or "subject." Merely keeping him in a treatment relationship, individual or group, as a minimal goal (and minimal goals with delinquents should not be scorned) taxes the therapist's ingenuity and capacities to the maximum. It is here that most failures occur. Since failure may mean further injury to the community and, eventually, to the delinquent himself, must not the therapist use himself as fully and responsibly as he can, exploiting every possibility for the maintenance of contact and the deepening of treatment involvement?

I know that this may demand much of the therapist, but surely the necessity of meeting such demands does not have to evoke frenzy because it comes with greater frequency and intensity than with other patients. While the delinquent may live desperately, the therapist can respond insightfully, therapeutically, and yet nondesperately.

In appealing for more treatment flexibility, both temporally and spatially, I am not unaware that this may give the appearance of methodological untidiness. I think, however, that we ought to value appearances less and therapeutic content more. Many cases, of course, will not require too much deviation from customary treatment methods, or if they do, this may be only a temporary requirement. Modifications should not be made indiscriminately in all cases, but rather in accordance with the requirements of each specific situation on a planned basis, if and as possible.

I see no alternative if we subscribe to a therapeutic model in work with delinquents.

Jacob Chwast
Lieutenant, Planning and Training, Youth Division, City of New York Police Department

STITT et al.: *A reply*

In commenting on our article in the March–April 1959 issue of CHILDREN ["Teamwork in Helping Families To Launch a Life," by Pauline G. Stitt, Joan G. Babbott, and Eva J. Salber] Dr. Edward Schlesinger makes the point that "Even if the clinic met only once a week, this would represent a tremendous concentration of high-powered personnel time . . . hardly a demonstration service in the sense of setting a pattern that might be followed even partially in a public maternal and child health program. The concentrated approach should be considered only as a research or training situation." [See CHILDREN, May–June 1959, p. 119.]

We recognize the validity of Dr. Schlesinger's observation on the concentration of professional time, and feel that this multidisciplinary longitudinal approach might be best used as an ongoing pilot study and staff-preparation project in a setting of teaching, standard setting, and research.

Dr. Schlesinger expressed further interest in how long the obstetrician functioned as a member of the team after the birth of the infant. The obstetrician was always a member of the total team which continued to serve the infant through at least the first year of his life, although his obstetric services to the mother usually terminated after the usual post partum visits. We share Dr. Schlesinger's feeling for the need for continuity of care and participation by both obstetrician and pediatrician well past delivery and the post partum period.

In the same "Readers' Exchange" section, Dr. Samuel Wishik stressed the importance of strong pediatric support by the pediatrician in the newborn period. Our wording, unfortunately, conveyed the idea that pediatric service for the child would not start until that child was 1 month of age. Actually this was usually the time of the first clinic visit the baby made but, in the meantime, there was some pediatric supervision in the hospital and at home. Since we share Dr. Wishik's feeling in regard to the pediatric importance of this period, we, too, would wish for most intensive pediatric service during the first few weeks of life.

The clinic admittedly did not solve the question of making itself readily available to working fathers. The practical difficulties of scheduling some time seemed insurmountable. We are convinced that an important area for further study would be to devise ways of insuring further participation of fathers.

Pauline G. Stitt, M.D.
Assistant Professor, Maternal and Child Health, Harvard School of Public Health, Boston, on behalf of Drs. Joan G. Babbott and Eva J. Salber

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

STAFF DEVELOPMENT AS AN INTEGRAL PART OF ADMINISTRATION. Hilda P. Tebow. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. PA Report No. 35. 1959. 33 pp. 25 cents.

Noting that staff development has a meaning broader than orientation, supervision, and inservice training, this monograph presents and interprets the principle that it is a day by day administrative process. The functions of the field supervisor in relation to staff development are reviewed to illustrate the theme.

HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY; acute conditions, incidence and associated disability, United States, July 1957–June 1958. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 584—Series B–6. December 1958. 47 pp. 35 cents.

Defining an acute condition as one that lasts less than 3 months (minor conditions excluded), this publication reports the number of such illnesses that affected persons in various age groups of the population, by sex, in the year ended June 30, 1958. Only conditions involving medical attention or restriction of activity were counted.

The study showed that the incidence of acute illnesses was highest in the youngest age groups and decreased progressively in each older group.

CHILDREN AND YOUTH IN AN URBAN ENVIRONMENT; a background statement. Housing and Home Finance Agency. 1959. 12 pp. Single copies available without charge from the Agency.

Written to assist groups preparing for the 1960 White House Conference on Children and Youth, this pamphlet discusses the effects on children and youth of changing urban environments. It suggests some subjects for Conference-connected programs, such as: including consideration of the special needs of children and youth in planning for growing communities; relocation of displaced families in ways that help children adjust well to new neighborhoods; community responsibility for helping families with problems due to bad housing and neighborhood conditions; effects on family living of increased time spent by parents daily in commuting from home to jobs. The pamphlet was planned as a result of cooperation between the Housing and Home Finance Agency and the Federal Interdepartmental Committee on Children and Youth.

THE CHANGING SCENE IN CHILD WELFARE; report of a conference with State welfare administrators and child welfare directors, including a Children's Bureau design for retooling in child welfare. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Reports No. 9. 1959. 61 pp. Single copies available from the Bureau without charge.

Promotion of progressive child welfare programs through partnership of the Children's Bureau and the States was the theme of the conference reported in this publication. Such partnership is exemplified in the statement, also included, which sets forth the goals of the Bureau's Division of Social Services and outlines a program leading toward those goals.

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Families and Urban Renewal

Children and Part-Time Mothers

Some Constant American Values

Parents of Retarded Children

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◀

FATHER AND SON beginning the day together. When both parents have jobs it is sometimes more convenient for the father to drop the child off at a day care center than for the mother. What a mother's sharing of her child care responsibility may mean to herself and her child is discussed on pages 213–218.

◄ the authors

For the past 10 years Jane Dale has lived and worked in Boston's West End as director of the more than 60-year-old Elizabeth Peabody Settlement House. Familiar to Bostonians far beyond the neighborhood because of its little theater—an outgrowth of a drama club formed to keep boys out of trouble—the agency's 45-year-old building was demolished last year. Before joining the settlement's staff Miss Dale was with the National Board of the YWCA, working for the USO in New Mexico, Texas, and Maryland.

Principal designer of the demonstration project he describes, James G. Banks joined the staff of the District of Columbia Redevelopment Land Agency in 1951 as chief of the relocation section. Previously he was for 5 years with the National Capital Housing Authority, successively as interviewer, tenant counselor, and supervisor of tenant selection. A graduate of Howard University, he has a master's degree in sociology from the University of Pittsburgh, and has attended the school of social work at Howard.

Besides directing the Philadelphia Child Guidance Clinic, John A. Rose serves as psychiatrist in chief at Children's Hospital in Philadelphia and as associate professor of psychiatry in pediatrics at the University of Pennsylvania. He joined the clinic as a staff member in 1946 after 4 years of wartime service with the U.S. Navy. Previously he was director of the Winston-Salem Child Guidance Clinic and head of the department of psychiatry at the Bowman-Gray School of Medicine, Wake Forest College.

Before joining the faculty of the University of California, Seymour M. Lipset was associate professor of sociology at Columbia University, from which he had obtained his doctorate. In a forthcoming volume, "Political Man," to be published by Doubleday in 1960, he elaborates on some of the themes presented in his article in this issue. He is also author of "Social Mobility in Industrial Society," published by the University of California Press in 1959.

Before World War II, Helen L. Beck taught nursery school in Vienna, Austria, and studied under Anna Freud, August Aichhorn, and others at the Vienna Psychoanalytical Institute. After coming to this country in 1940, she taught nursery school for a while before turning to a social work career. Since receiving a master's degree in social work at Bryn Mawr College in 1946, she has held various social work positions in the family service and mental health fields.

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FAMILIES AND CHILDREN IN URBAN REDEVELOPMENT

I. A View from a Settlement House

JANE DALE
Head Worker, Elizabeth Peabody House, Boston

THE POSSIBILITY that half of the West End of Boston would be razed as a part of the federally sponsored urban redevelopment program had been talked about for 10 years. There was considerable newspaper and other publicity in the months preceding actual landtaking, as well as educational efforts by local schools, churches, and social agencies. Despite this, landtaking notices received in April 1958, triggered a crisis in the lives of most of the people in the area.

With the area's 2,800 families now relocated, the Elizabeth Peabody Settlement House has tried to assess this neighborhood crisis—with particular reference to its role—in the hopes that some useful knowledge may be gained which might be utilized in future urban renewal projects throughout the United States. With its goals of strengthening family life and helping in the growth of healthy neighborhoods, the agency fully supported the idea of redevelopment and had been planning with other agencies in the area to help the families meet their problems of relocation. However, it now has the advantage of hindsight in seeing how and where earlier preparation for redevelopment on the part of all the agencies in the community working together might have helped to ease a very difficult situation.

Redevelopment of as large a residential area as the West End was a relatively new, untried effort in 1958—even for the professional government personnel involved. It certainly was a complete unknown for the Boston community as a whole, for West End residents, and for West End social agencies and institutions.

Under the law through which the city had obtained Federal funds for redeveloping the area, the 2,800 families had to be relocated in safe, decent, and sanitary buildings. Each family could be offered up to $100 for moving expenses and any assistance the site relocation office could provide. Thus, the lawmakers broadly recognized that individual problems would be posed by relocation and took steps toward their solution by providing for a site relocation office. However, what is now obvious is that the assistance which must be provided to the families of any area to be cleared must come in large part from the resources of the community as a whole, working with the relocation staff. The assistance needed is too great, too varied, and too specialized to permit solutions by any one staff.

The neighborhood crisis, which spanned the period from landtaking until actual relocation of all 2,800 families in the area, developed from the very obvious conflict between the inevitable relocation of the West End families and their strong reluctance to move elsewhere. While the West End was considered by the experts to be one of Boston's worst residential areas, it was believed by its residents to be a most desirable place in which to live.

Although the difficulties of inadequate housing, tenement buildings, dirt, disease, and lack of recreational space caused tensions and strains in the lives of West End residents, the West End held charm and for many people represented security. The stability of longtime residence, the nearness of parks and pools, the familiarity bred of close living conditions, the richness of many cultures—Jewish, Polish, Irish, Albanian, Ukranian—were some of the more pleasurable aspects of its life which served to draw the people closely together. Within walking distance of the people's homes were informal cultural groups, work, churches and synagogues, nationality food stores, and a variety of social agencies. A great many West Enders valued the social environment of this "slum area."

Some Problems

Although relocation in fact became the turning point for some West End families in the improvement of their lives, for others it intensified many existing problems which, unless resolved, would exact a toll from both the individuals concerned and the new communities to which they have moved.

In the West End, the Boston Redevelopment Authority assumed ownership of all property at the the time of landtaking for payments of $1. As of the date of landtaking, rents had to be paid to the authority until the building was vacated. At a later date, assessors determined the further amounts which the authority was willing to pay for the property taken. If the former owner thought this price too low, he appealed and requested a higher figure, but an appeal meant further delay—in many cases more than a year. While in some cases of hardship former landowners were not required to pay rent until they were paid for their property, this was not a publicly stated policy.

Among those hardest hit economically were residents who had their own apartments or stores in a building which also provided them with rental income. Not only did this income stop with the landtaking, but suddenly they had to pay for the space which they used in the building. In the case of the small retailer, an added problem was a drastically diminishing market for his goods or services as the West End was vacated. When payment for their property was not forthcoming, these small businessmen could not afford to move elsewhere. Such problems generated considerable hostility.

Another group seriously affected by relocation, and hence resentful, was the marginal wage earners who had been able to "squeak by" in the West End during periods of unemployment because of extremely low rents (some families had been paying only $12 a month for a three-room apartment). Other West End families had been planning for relocation by gradually accumulating savings over the years which would permit them to achieve a specific goal. Unfortunately, landtaking came for many of these long before sufficient savings had been accumulated, so that they had to revise the plans they had formulated and worked for over several years.

Confusion and misunderstanding regarding the role of the relocation office persisted among many of the residents.

The morale of almost all families was affected by being socially uprooted from an area with which they had had strong ties. Those who were not the first to go were further depressed by living in crumbling and deserted neighborhoods.

Although most families functioned very well during this trying period and planned and executed their moves with little or no outside help, the families who did not or who had special problems required a disproportionate amount of the relocation office's time. Many families made no plans to move and when the wrecking company was ready to start on their building, they had to be temporarily relocated elsewhere in the West End, thus merely postponing the problem. Sometimes the alternative to temporary relocation within the West End was a poorly planned, hasty move, likely to be productive of later problems.

A street in the West End of Boston before demolition of the neighborhood to make way for the area's redevelopment.

Regard for property almost disappeared in the West End during the relocation period. Destruction and demolition became a favorite game among the children, and neither parents nor authorities seemed concerned. Vandalism and truancy among teenagers became common. The adolescents seemed to be acting out all the insecurities and antagonisms that their parents were feeling. Since much of this behavior was not effectively checked, these problems will undoubtedly be inherited by the communities to which these teenagers move.

There seemed to be a general abnegation of parental responsibilities during the relocation period. Many parents seemed to feel that their children's school and behavior problems were relatively unimportant in comparison to their own problems of moving. While these parents may try to reassert their influence after a move is made, this period of "not caring" may create some permanent problems in the families and in their new communities.

Community Organization

In spite of these problems, the West End was perhaps more fortunate than many areas may find themselves in facing redevelopment. First, as has been mentioned, the area had for years been served by many social agencies and churches. This meant excellent knowledge of much of the community, as well as established lines of communication which could be utilized in the interest of relocation. These groups had for years been associated with each other in the West End Neighborhood Council, which meant that the agencies had considerable knowledge of each other's work and that their staff members knew each other well. This readymade basis for cooperation and community organization compensated a great deal for the agencies' general lack of experience in the problems of relocation.

During the 10 years leading up to actual landtaking in April 1958, the neighborhood council was very much concerned with the approaching redevelopment of the area. Over these years, considerable rapport was established between the council and key persons in the Boston Housing Authority and later the Boston Redevelopment Authority, the agencies successively responsible for redevelopment of the West End. The council stressed the need for clarity regarding definite plans for the West End's future. The redevelopment representatives on the other hand informed the council members of the exact nature of redevelopment and the timing of its various phases. This early relationship between community agencies and the redevelopment authority provided a two-way line of communication between those responsible for redevelopment and the community itself, which could be used in efforts to prevent or minimize confusion, doubt, and distrust within the neighborhood. It also provided the redevelopment authority with a community group on which it could call when problems of actual relocation demanded active working groups of West End agencies and individuals.

At one point before landtaking, arrangements were made through the neighborhood council for the West Enders to take a trip to one of the city's public housing projects, in order to show residents an alternative to living in the West End. More of this kind of activity would probably have been worth while at that early date, although at the time it seemed somewhat premature. As it turned out, although most West Enders were eligible for public housing, few moved into such projects. They evidently regarded proximity to persons of their own culture and to nationality food stores as more important than better housing at a lower rent.

Some time before landtaking a large open meeting was held at the Elizabeth Peabody House at which the redevelopment authority spoke of plans for the West End. However, subsequent smaller meetings with leaders both well informed and capable of handling discussion proved more effective in gaining citizen participation and understanding. More of this kind of activity might have helped lessen later problems.

Neighborhood Committees

Four months before landtaking, the neighborhood council with staff service from the United Community Services established two committees from the West End to work with the relocation office:

1. An interpretation committee composed of lay leaders of the various West End social and church groups. This was charged with communicating facts about relocation from the relocation office to the community and with explaining some of the neighborhood's concerns to the office staff.

2. A case committee, composed of staff members of the neighborhood's social agencies. This was charged with interpreting the agencies' services to the relocation staff and with referring to the appropriate agencies families found by relocation staff to be in need of help.

These committees were staffed by a social worker provided by the United Community Services, who had to spend considerable time—as did staff of the Elizabeth Peabody House—in gaining the confidence of the indigenous leaders in the interpretation committee and in helping them function as committee members.

The work of an interpretation committee could be the key to a successful relocation program. The effectiveness of the West End interpretation committee in what it undertook only emphasizes in retrospect how little it was used in relation to its potential. Clearly, the committee should have been established very much earlier and should have included, as well as leaders of church groups, local business leaders, politicians, and representatives of the various social agencies.

The case committee helped to bring about the establishment of the position of a caseworker on the relocation staff to be paid for by the Federal Government; but unfortunately, it was impossible to fill this position in the West End until most families had been relocated.

Settlement House Program

During the relocation period the neighborhood council provided a meeting ground for arranging cessation of the agencies' services in the area. The various agencies were thereby aware of what services were to be terminated and when. The Elizabeth Peabody House's program in the last year was largely determined by an effort to offer services that no other agency was offering. Some of its services and those of other agencies were transferred to agencies on the outside fringe of the redevelopment area to ease the effects of the West End agencies' departure for families who, although living outside the area, had been served by West End agencies for many years.

The program of the Elizabeth Peabody House in this period actually evolved as new needs and mistakes became evident. Moving in the West End from a 10-story to a smaller building, we were forced to reduce our services to the neighborhood to include only activities that might help the families in meeting their relocation problems. While a sociologist advised us to spend all our time trying to follow our 1,000 members and help them assimilate into their new community life, we felt that we must also continue to provide services to families who had not yet moved. Since we had neither the funds nor the staff to do both, we persuaded the State Youth Service Board to assign a community worker to the House to help teenagers as they moved to new communities to find and participate in whatever constructive activities the new neighborhood had to offer.

Flexible Service

Our West End program necessarily had to be flexible. Through trial and error we learned that the remaining teenagers most needed a place to congregate as their familiar meeting places were torn down and some preparation for new experiences. Therefore we continued to offer them friendship clubs and increased the number of teenage lounges (informal, supervised social evenings) to two a week. Joint programs with other agencies and the transfer of some groups, such as Scouts, to nearby out-of-neighborhood agencies helped ease the burden.

We found that leadership of teenage groups during the demolition period needed to be both consistent and of the highest caliber. Leaders were sought out who through acceptance, understanding, interest, and helpfulness had established positive relationships with teenagers under normal conditions. They encouraged the teenagers to plan programs that might aid in their transition to new neighborhoods, such as trips to youth-serving agencies, visits to members no longer living in the neighborhood, joint social activities with members of other agencies, and increased use of community resources accessible to members of the larger community.

To our surprise we found that the best service we could give to some teenagers was to separate them gradually from our service, for our programs were drawing back to the West End teenagers who had already moved out but who were finding it difficult to assimilate in their new neighborhood. For these and others we kept on display a large map of Greater Boston on which were pin-pointed the Red Feather youth agencies and recreation centers of the Catholic Youth Organization as well as the new locations of former Peabody House members. In some instances we tried to interest school officials and pertinent agencies in areas of resettlement in former West Enders whose continued presence and disturbing behavior in the West End seemed to point to poor adjustment to their new neighborhoods.

We were also surprised to find that the women still in the neighborhood did not want to come to meetings to discuss their relocation problems. What they did want, and therefore what we offered them, was an opportunity to drop in for an informal evening of crafts and a cup of coffee. In this relaxed atmosphere they would often bring up their problems, thus enabling our staff to keep in touch with the neighborhood situation and to identify areas where help might be offered.

We also invited parents to meetings with a United Community Services information staff member to let them know of resources in new communities. We held reunions inviting remaining West Enders to meet with old neighbors who had made successful moves, and took groups to housing projects and to communities to which old neighbors had moved.

For the younger children we provided group activities such as games, arts and crafts, or dramatics, to give them some sense of security as the buildings were torn down around them and their parents became more distracted.

Our detached workers helped many families and the relocation office in times of particular crisis. This sometimes meant acting only as a referral and information center, but often it meant helping a family move at the time when their building was slated for immediate destruction. Our workers did not relocate the families, in such instances, but helped to identify their problems and to interpret these to the relocation staff. At the same time we helped the family members face the fact that it was impossible for them to continue to live as in the past and tried to make them see that the relocation staff was there to assist them with their problems of moving.

Lessons Learned

Other agencies serving the neighborhood also worked closely with the relocation staff and in many instances revamped their programs to meet the special needs of the relocation period. Families receiving public assistance under the Aid to Dependent Children program were relocated early as it was not a suitable neighborhood for children. Representatives of the family health program at Massachusetts General Hospital and of the Visiting Nurse Association pointed out their patients' special housing needs to the relocation staff. The Girl Scouts and Boy Scouts referred members who were moving to troops in the new neighborhoods. The Campfire Girls continued their West End day camp and opened it to West End girls who were not members. The State placed three recreation workers in its park at the edge of the neighborhood, since there was no play area for children in the disappearing neighborhood. Child protective agencies provided service in cases of child neglect uncovered during this period.

Considering the lack of experience of almost everyone concerned with the relocation of families in the West End, as well as the newness of urban renewal nationally, we feel that generally performance in the West End was of an extremely high caliber. Despite this it is obvious to us now that there are areas of activity that could have been improved.

First, we believe that almost every kind of assistance rendered West End residents would have been more effective had it been initiated earlier and been more comprehensive. Probably the strongest obstacle to providing such help was time. Too often a problem—either an individual or a general one—was identified either after damage had been done or after the point had passed at which there was time to solve it.

Since a door-to-door initial survey is made of an area by the redevelopment authority some months before landtaking, many problem families could probably be identified at that time by the addition of some questions designed for this purpose. This would permit the agencies concerned to plan an effective program in advance of landtaking.

Secondly, interpretation of redevelopment cannot be too thorough if the kind of environment is to be created that will permit effective assistance. The support of a community's indigenous leaders is vital.

Thirdly, attempts must be made to bridge the gap

Teenagers climbing on the rubble beside the old home of Boston's Elizabeth Peabody Settlement House as the demolition stage of the West End renewal project proceeds.

between those that can give assistance and the following two groups of residents:

1. Families who have had no contact with the agencies, who are unfamiliar with the assistance that is available, and whose problems are brought to the surface by relocation. This group can probably be very effectively helped by a caseworker on the relocation staff.

2. The chronic-problem families whom many agencies assume they have neither the money nor the staff to serve. Urban renewal offers a chance to make valuable research contributions to both a specific community situation and a general problem presently challenging the whole field of social work.

Next, much more can and should be done to aid in the assimilation of relocated families into their new environments.

Lastly, the West End experience has demonstrated how important it is for the social agencies in an area to be redeveloped to attempt in advance to project the needs of the community during relocation and plan their programs in accordance with these needs, even, if necessary, at the expense of their previous patterns of service. Since such projections are not easy, flexibility in programing will be necessary to achieve greatest service to the neighborhood.

In summary, the West End experience indicates that three kinds of assistance must be provided to residents of a redevelopment area: (1) help in accepting the inevitability of their move; (2) information and aid in actually getting themselves moved to a suitable new community; (3) help in making an adjustment to their new location. Obviously, the relationship between the Government relocation office and the community's agencies and institutions in providing this assistance will depend on the number and character of the agencies and institutions directly concerned with the redevelopment area. The job to be done remains the same, however, and whatever resources the community has must be organized to give this help.

II. A Demonstration of Services

JAMES G. BANKS
Chief, Project Management Division, District of Columbia Redevelopment Land Agency

THE IMPACT of urban renewal upon the social processes within our cities is slowly gaining attention. The displacement of families from their old neighborhoods has brought to the fore social problems which have made many communities realize that the provision of decent housing does not alone remedy the social and physical conditions we call slums.

In Washington, D.C., a demonstration project is being conducted which will focus the city's attention upon the services which must accompany decent, safe, and sanitary housing if the elimination of slums is to be lastingly effective.

Washington began its urban renewal program with the displacement of 1,300 families from a 100-acre site known as Project Area B, just south of the Capitol. The families—predominantly Negro—had an average annual income of less than $2,000 and lived in the worst housing in the city. Seventy-five percent of the dwellings were without inside running water, more than 50 percent were without gas and electricity, and more than 75 percent were considered dilapidated according to the appraisal technique of the American Public Health Association. The area had a high incidence of crime and health problems.

The District of Columbia Redevelopment Land Agency's relocation staff was located within this area to assist families in finding decent, safe, and sanitary dwellings. The redevelopment agency recognized from the beginning that in the course of relocating families social and health problems would arise which would require solution if relocation were to be effective. To meet this need, the agency called together representatives of most of the city's social and health agencies to form an advisory committee. The committee was helpful in advising on specific types of problems such as methods of referral for service, and individual agencies were most cooperative in assisting some families. However, though the relocation of all the families from this area was satisfactorily accomplished, the social welfare needs of all of them were obviously not met. Moreover, it became clear that unless the community's welfare agencies fully recognized their responsibility in the total redevelopment program and unless there was some realignment of social services, many advantages of urban renewal would be nullified.

Upon completion of the relocation of the families from Project Area B, the Washington Urban League assembled a group of interested agency representatives to study reasons for the lack of coordination and the frequent lack of cooperation among the city's social and health agencies. After participating in this study for nearly a year, the redevelopment agency proposed a special project to demonstrate procedures and methods which might be used to coordinate social and health services to meet the individual needs of the thousands of families scheduled to be displaced from their homes.

The redevelopment agency secured the assistance of the staff of the Health and Welfare Council of the National Capital Area in developing a comprehensive plan to obtain the cooperation of all of the city's social and health services to help the displaced families.

This proposal was submitted by the redevelopment agency to the demonstration branch of the Urban Renewal Administration of the Housing and Home Finance Agency, with a request for demonstration funds available through the Housing Act of 1954.[1] The Urban Renewal Administration approved the application and authorized a budget of $248,830, of which $165,796 is being made available by the Administration and $83,034 from local resources in the form of services provided by social and health agencies and cash from a foundation. As a result a demonstration is now being carried on in the Southwest Urban Renewal Project C, conducted by the Health and Welfare Council of the National Capital Area under contract with the redevelopment agency.

The basic aims of this demonstration project are:

1. To develop educational and community organization methods to assist families in (*a*) making wise housing choices and (*b*) adjusting to their new neighborhoods.

2. To demonstrate the kinds of social and health services which must be provided in order to reduce the likelihood that slum habits among displaced families will continue in new and better neighborhoods.

The staff recruited by the health and welfare council to conduct the demonstration consists of the following: director, casework supervisor, three caseworkers, two community organization workers, statistician, administrative assistant, receptionist-typist, and two stenographers.

The project includes three types of activities: community education; community organizations; and casework services. While considerable interplay takes place among them, each has its special emphasis and goals.

The program began with a comprehensive survey of all families within the project area, data from which were used in establishing approaches for offering services to families. Special attention was given to the social and personal problems of the residents and to the types of services they were receiving. The survey revealed that while most families had some understanding of what urban renewal was about, few seemed to relate the overall purpose of the program to their own plight. Many had so intertwined fact with rumor that they were thoroughly confused.

Community Education

In the summer of 1958 a series of small meeting of area residents began with the purpose of bringing simple yet complete explanations of each phase of the urban renewal program to the families. These orientation meetings provide individual counsel to families in planning their moves and offer an opportunity for free discussion of personal problems and attitudes connected with the program. Each meeting is restricted to not more than 30 persons. After informal presentation of information by personnel from appropriate city agencies, the residents form smaller discussion groups from which come questions which are frankly answered when the entire group is reassembled.

Special efforts are made to assure participation in the educational program by residents from all parts of the project area, representing all strata of the

Left, four children and the alley dwelling home from which they had to be relocated before it was torn down in the redevelopment of Washington's Southwest area. *Right,* a member of a relocated family admires the plumbing in her new home. Many families who moved from the now demolished Southwest slum areas today have indoor bathrooms for the first time.

population. The names and addresses of all participating residents are carefully recorded and mapped. Recruitment is accomplished by use of flyers, personal interviews, and referrals from organizations within the area such as churches, parent-teacher associations, the two settlement houses remaining in the area, and a health center operated by the District of Columbia Department of Public Health. A third settlement house closed soon after the redevelopment program began.

Out of the orientation discussions grew an awareness of the need for special discussion groups concerned with the specific problems of different members of a family. Thus the home buyers' group, the mothers' group, and the teenagers' group were formed.

Each of the groups has held regular meetings to discuss their participants' particular problems related to urban renewal. For instance, the teenagers' group has had discussions of personal hygiene, while the mothers' group has been concerned with learning about the mechanics of school transfer and the like.

Home Care Demonstrations

The orientation discussions also focused attention on the obvious need for special education programs to help families unfamiliar with basic housekeeping and home planning methods. With the cooperation of the adult education division of the District of Columbia public schools, a special education program for displacees, called the Home and Family Living Series, was inaugurated last January. The first series has offered courses in family clothing, personal and family health, family foods, and do-it-yourself methods.

In these courses a reporting form is furnished instructors, who make recommendations and weekly notations of the participants' reactions and suggestions. Each course is geared to the needs of families of limited income. The do-it-yourself course helps the residents to make or restore home furnishings and equipment. The family food course emphasizes the best use of surplus foods and low-cost groceries. Registration for all courses has consistently increased since the beginning.

Community Organization

An integral part of the community organization service is the program for the neighborhoods to which large numbers of displacees move. For example, the project has placed community organizers in two public housing developments to be responsible for developing and encouraging programs in the surrounding community and to help the newcomers become acquainted with and adjust to their new neighborhoods. A similar program is under way in a neighborhood of private homes.

The efforts of the community organization workers are directed toward the involvement of existing neighborhood agencies so that when the project is completed the programs will continue. They familiarize themselves with existing programs and organizations in the communities, and through personal interviews or printed matter encourage new residents to participate. Leaders of indigenous neighborhood groups are encouraged to reach out to the new residents to help them to feel a part of the community.

Numerous public and private agencies are participating in this neighborhood work, including the city recreation department, civic associations, the Saint Vincent De Paul Society, the Salvation Army, and settlement houses. For example, one civic organization, which at first strongly objected to the construction of a public housing development in its neighborhood, after the new housing was occupied helped the project worker to secure additional recreational and other needed services for the neighborhood.

The community organizers in public housing developments work closely with the housing managers and have the use of apartments in the developments for demonstrating good housekeeping techniques. Most of the furnishings, including some of the furniture for the demonstration apartments, have been made by displacees working in the Home and Family Living Series. Other furnishings have been lent by the Saint Vincent De Paul Society, the Goodwill Industries, and the Salvation Army. A sewing machine company has lent machines for use in sewing classes.

Health Education

Because some residents of the project area seemed to be misinformed or hesitant about the use of the health facilities of the city and the neighborhood, a portion of the local contribution toward the project's budget is the full-time service of a public health nurse of the District of Columbia Department of Public Health. Working under the supervision of the project director, she instructs residents in how to use the city's health services, and assists them in making appointments.

The nurse also gives instructions in prenatal care, nutrition, accident prevention, sex hygiene for adults, care of the sick in the home, and babysitting. She leads small groups of not more than 12 persons, demonstrating how to take care of infants and bedridden patients. In one class a mother of 10 children, who after giving an awkward demonstration of how she bathed her baby, said that she had never been taught the basic essentials of child care. A similar lack of elementary child care techniques among many of the families in the area is accompanied by an eagerness to learn, which has been a constant source of encouragement to the staff.

A special class in babysitting techniques has been introduced to help youngsters who care for their younger brothers and sisters during their parents' absence from home and for those who wish to make extra money caring for their neighbors' children. Recruitment for this course, made through school principals and publicity flyers, was extremely successful.

Casework Service

One of the major phases of the project is its casework service to a selected group of demonstration families. Acting mainly as a catalyst in the casework area, the project's caseworkers devote most of their efforts to thorough investigations of families' needs, aggressive efforts to get families to seek help with their problems from the appropriate community agencies, and coordination of casework planning for individual families. Counseling is offered by the project staff where appropriate services are not available from existing agencies.

In one instance caseworkers from the public welfare agency's child welfare division and public assistance division and from a local hospital were invited to meet with the project's casework supervisor and a representative of the redevelopment agency to discuss the situation of a family including eight children whose parents were regarded as mentally retarded. Five of the children had been removed to an institution for the mentally retarded, the family had no steady income, and the redevelopment agency had not been able to help the family plan its move. As a result of the conference, arrangements were made to reevaluate the mental condition of the parents and the children. The reevaluation showed the mother's intelligence as almost normal and the father as capable of unskilled, supervised employment. The child welfare division investigated the possibility of returning some of the children to the family and providing continued casework help. The father was helped to obtain a job as a carwasher, and the public assistance division supplemented this income. Through these combined efforts, the parents were helped to achieve more confidence in themselves, and this was reflected in improvement of the quality of their child care. Plans are now being made to place the family in a public housing development, and to return some of their absent children to them.

The casework services are begun while the families are still living in the redevelopment area. When the families move away, the caseworkers continue coordinative and counseling services in the new location. The plan of the casework service is to provide a minimum of 6 months of service to the families in their new homes if continued service is necessary.

There is constant interplay between the community organization, education, and casework services. Caseworkers refer persons exhibiting need for special training or group activities to the community organization and education workers, who involve them in appropriate training or group activities. The workers consult one another regularly on the families' progress.

Included among the project's caseworkers, and counted as a part of the local contribution toward the budget, are two caseworkers from the public assistance division of the District of Columbia Department of Public Welfare. These workers are supervised within the project, and their work is geared to the project program.

Evaluation

The evaluation goals and methods were built into the program from the beginning. Two social research specialists, one statistician, and a social research firm were employed to map out a program that would test the efficacy of the community organization, education, and casework efforts.

Names and addresses of all participants in the various aspects of the demonstration are recorded to enable the personnel to see that persons from all sections of the project are included, and to permit cross-references between the three phases of the demonstration. Expressed attitudes of participants in community organization and education programs are also carefully recorded to permit evaluation of their growth and change. A nonparticipating observer, invited to each meeting, renders a written report of his impressions of the meetings' contents and the participants' responses.

In order to determine the effectiveness of the coordinated approach to casework, a group of 200 families, called demonstration families, representing a cross section of area residents, was selected to receive the special services. Another group of 200 families with similar characteristics was selected as the control group. Each group includes approximately 485 children. Families falling within the control group receive no assistance from the demonstration staff. If such families request help they are referred to an appropriate community agency.

The original survey established the needs and conditions of all area families. A final survey especially designed to measure social movement among families will be carried out when the demonstration services are concluded. Comparison of changes occurring within the demonstration families and those in the control group will be made to determine the effectiveness of the coordinated casework approach. The changes to be noted will include changes in children's school progress, regularity of parents' employment, participation in civic activities, and frequency of contacts with law enforcement agencies.

This project is prompted by the resolute belief that the talents of slum dwellers and their potential contributions to the community can be realized only through coordinated efforts of all of the city's resources. It has been designed to encourage among the people it serves the development of more self-esteem and a willingness to venture out to accept the opportunities and responsibilities in their new homes and neighborhoods.

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[1] Public Law 560, 83d Cong., August 2, 1954 (Ch. 649, 68 Stat. 590).

We may either smother the divine fire of youth or we may feed it. We may either stand stupidly staring as it sinks into a murky fire of crime and flares into the intermittent blaze of folly or we may tend it into a lambent flame with power to make clean and bright our dingy city streets.

Jane Addams in The Spirit of Youth and the City Streets, *MacMillan Co., 1909.*

CHILD DEVELOPMENT AND THE PART-TIME MOTHER

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IT IS STILL widely assumed that damage to child development is the inevitable result when the mother is employed. However, research findings and clinical experience both indicate that there is no simple cause-effect relationship between the two factors of maternal employment and developmental damage. In fact, in many situations maternal employment and deviate development in the child may have common causes. In others more damage might occur to the child if the mother were not employed. True, a mother's need to be employed introduces complications into the mothering process and hence, into the process of child development, but these are not necessarily unfortunate and they are by no means confined to the problem of the working mother.

In our culture we tend to be doctrinaire about the needs of women and children without allowing for exceptions. While there is wide, though far from unanimous, acceptance today that a woman can have both a domestic and a working career, there is less acceptance of the idea that the combination might be good for the development of her children.

Many women go to work out of economic necessity. Others undoubtedly seek careers as a flight from child bearing, child rearing, and other domestic roles, as a protest against their perception of the role of women in our society, or as a result of family disunity and failure. These women, however, are probably fewer than the number to whom the domestic roles bring value conflicts but who do not go out to work. They accept the popular assumption that the employment of mothers outside the home is inherently in conflict with the needs of family unity and child rearing.

Milton Senn [1] in his recent survey of child-rearing problems of working mothers in Russia concluded that there need to be no intrinsic conflict in the roles of mothers and working women since he found no destructive effects among the children involved. This does not necessarily hold true for our culture. While in our culture some families have shared child-rearing and domestic tasks with relatives and employees for many generations without excessive harm to child rearing, there is still the social expectation that nondomestic tasks *should* be less gratifying for women than child-rearing tasks, and that gratification of the former must be at the expense of the latter.

The problems arise from conflicting trends in our culture: (1) an emphasis on the value of woman as a person independent of domestic functions and (2) fewer opportunities for women to share the child-rearing role with relatives as families establish themselves in small independent units.

The conflict is abetted by the tendency of employers to make little allowance for women's child-rearing activities and by the fact that the child-rearing role has become more self-consciously exacting than in the past.

During the last half century there has been a continuous emphasis in the health, welfare, and education fields on the developmental needs of children. Foster care agencies have found that children develop best in a climate of family relationship.

Based on a paper presented at the 1959 Conference on Family Living of the Family Service of Philadelphia.

Health agencies have become increasingly aware that warm human relationships are vital to survival as well as to the qualitative aspects of character development. Social legislation has made it possible to maintain family integrity under circumstances which formerly would have forced a child into foster care. Thus a consistent social preference for situations which would strengthen the unity of the family and foster closer relationships between mother and child has been enhanced. At the same time pediatricians and others engaged in parent education have been advising parents to have greater intimacy with, and investment in, their child.

These emphases seem to have increased the sense of personal responsibility in mothers (and fathers) for the development of their children in a healthy and *socially approved* way. The effect seems to have been to bind women more closely to their children and at the same time to complicate the basis for getting gratification from their children. Thus today many mothers seem uncertain of their capacity for nurturing their children constructively, but do not feel free to seek gratification in other areas.

Uncertain Mothers

This problem of the feminine role may be the basis for the increase in the number of severely disturbed children coming to the attention of child guidance clinics today. A woman's own experience in being reared may have left her with fears that mothering is an unrewarding task. From this experience, or from her family's attitudes toward females, she may be uncertain as to whether she wishes to carry out the mothering role. She may, of course, also have more complicated neurotic fears about the feminine role.

Moreover in some instances the situation may be loaded with negative factors. For instance, early illness or defect in an infant may increase the burdens and decrease the rewards of mothering. Then, too, as Calvin Settlage [2] has remarked in his presentation of the problems of limit setting in child rearing, people in a state of social mobility and changing values are highly uncertain as to what to expect in child behavior and performance.

Uncertainty, ambivalence, and doubt can often be resolved by experience. But unfortunately uncertainty and ambivalence in maternal attitudes and feelings are manifested in tensions which are communicated to the child. Disturbances in children emerge as a consequence of this process and these tend to increase parental uncertainties. Once initiated, this vicious circle tends to be aggravated by closeness and relieved by various amounts of separation.

Such circular patterns of disturbance are less likely to occur when the mother has other areas of striving from which to gain status and through which to relieve the feelings of inadequacy evoked by the child. Circumstances which tend to decrease the opportunity for emotional and social experience outside the child-rearing task tend to increase the degree of inner conflict in uncertain mothers and so to worsen the prognosis. Conversely, opportunities to share the care of the child with another person tend to decrease the vicious circle of disturbance and tension.

There are many ways in which mothers can gain some separation from the child. Some are obviously in flight from disturbance and will be considerably guilt laden. Others can bring the mother both perspective and status.

The request of a mother for psychiatric or casework help for herself, her child, or other members of her family is usually an indication that she is searching for a more satisfying life for herself. This bodes well for success if she does not lose status in the process.

The decision about whether or not a mother needs to work outside the home should not be made on a purely economic basis, any more than should the decision in the placement of a child. The emotional factors should be the decisive ones.

There are many mothers who come to understand from symptoms in their child that they must do something about finding satisfactions beyond the child. There are others who understand from their experience in neonatal care that their future ability to give good care will depend on their following other interests or on going to work. For healthy child development one may not ask too much return from the child without creating problems. When a mother's need for satisfaction transcends in nature or quantity the emotional return that can generally be expected from child rearing, distortion in the child's development provides a cue to the mother to seek appropriately what she needs.

Some Impediments

Unfortunately changes in family living patterns and social and medical child-rearing doctrines are apt to impede this search.

The smallness of families today affords mothers fewer positive opportunities for getting away part of the time from the intimacy of child care. A general, if partial, solution to this problem is, of course, the babysitter. But this may involve other problems.

Recent newspaper stories of babysitters who have tried to steal babies are a reminder of the problems of motivation in substitute mothers. For the most part family arrangements with nursemaids and babysitters involve some unconscious testing of the mutuality of feelings and expectations. When disturbance exists in a family and when the mother's need to get further away from the child is rather intense, there seems to be a greater likelihood for the choice of a substitute mother with bizarre or disturbed motivation. In a way this phenomenon resembles "accident proneness," in that accidents so frequently happen to children when a harried and disturbed parent is unable to give the child adequate attention. It suggests that some of the same factors which operate to make a family's child care unsound in any way operate in their choice of a substitute mother.

In general the ground rules for substitute mothering are not too different from those of own-mothering. States of excessive need to gain gratification from child care, projection of states of deprivation on a child, intense fantasies of the need to rescue a child from his oppressors—all are likely to cause difficulty in the rearing of children. So also are resentment of children perceived as "spoiled" and strong feelings that the child should belong to the substitute mother in restitution for what she has lost in life, either through reality or neurotic mechanisms.

This means that social and health agencies should have careful checks and balances in any program using volunteers. Volunteer programs of children's hospitals stimulate not only many well-motivated women to service but also a considerable number of women more undesirably motivated. Perhaps the wish to be closer to children sometimes needs as much scrutiny as the wish to be away from them. Every public program involving day care, nursery school care, hospital care, convalescent care, and the like has a responsibility for conducting careful screening operations for insuring well balanced motivation in its substitute mothers.

Social and medical doctrines which tend to push a mother closer to her child or make her feel guilty for attempts to get away may contribute to an increase in symptomatology in both child and parent. Unfortunately mothers burdened with guilty feelings often present themselves as in need of punishment, and unfortunately, too, many professional persons are willing to oblige them in this respect. This may be temporarily relieving to the mother but it is not a process apt to produce enduring maternal satisfaction and long-range improvement in child development.

Pressures from such doctrines may be a large factor in the apparently increasing incidence of emotionally disturbed children. Professionals in health and welfare, as well as judges and public figures, sometimes lose sight of a child's developmental needs as they actually exist in his particular life situation. Thus in some instances authorities insist that parents establish a stable home for their children, when the obvious degree of disturbance in the children involved makes this unfeasible.

Sometimes social doctrines in regard to the values of family unity and child care in their own home result in the return of a child to a mother actually too sick, with much internal conflict, and too disturbed to bring anything but destruction to the child's future development. Mothers who have become mentally ill in conflict with domestic childbearing and child-rearing roles are not good candidates to resume the responsibility when their illness abates. The sanction of such arrangements by psychiatrists who have the mother as a patient suggest that there are some who would sacrifice the child to the mother's needs. The return of neglected or delinquent children to conflicted families sometimes seems to be done on a theoretical basis rather than in relation to the child's need.

Arrangements for Care

In my observation of cases seriously mentally ill mothers whose internal problems force them into continued and conflicted intimacy with their children are rare. Rather I have noted that generally a mother in trouble with child care tends, rather spontaneously, to seek solutions which are beneficial to her and to the child. I have also been impressed with the fact that mothers who need to perform in other areas are not less interested in their child's development than other mothers.

Few mothers can bear any long-term plan that is damaging to the child.

Examinations of various arrangements for sharing of child care suggest that the complications involved spring partly from (1) maternal conflict, partly from (2) the social situation in which it occurs, and partly from (3) the attitudes of the person or persons with whom care is shared.

In informal types of shared child care, a mother or sister of the mother is the other person most frequently involved. In instances in which such a plan is based purely on flight from the care of the child, such arrangements become informal placements of the child and may have a tragic result. The greatest disadvantage in informal placement lies in the tendency of such arrangements to break down suddenly without regard for the needs of the child. For instance, a grandmother who has been giving child care may find herself unable to make the necessary investment as she and the child grow older.

In some instances, an older sibling becomes the person giving care to younger ones following their mother's death. Such an arrangement invariably results in excessive sacrifice and is usually productive of longterm developmental problems in the mother surrogate and the siblings.

Split Authority

When mothers make informal arrangements for child care with members of their family problems often arise out of differences in their own and the surrogate's expectations of the child and from questions of authority.[3] Conflict may be severe when the mother's mother is the governing authority and the mother becomes in a sense a sibling of her own child. When such conflict occurs the child's loyalties may be split as when mother and father differ strongly. Obviously persons sharing the care of a child ought to agree closely about what can and cannot be expected of him at his stage of development.

The problems of authority have endless permutations. Many young mothers are thrown into severe conflict by the superior experience and adequacy of employed practical nurses. Sometimes because of her subordinate position to the mother a practical nurse will conceal her differences in opinion and feelings of rivalry. Usually when the mother surrogate feels inferior to the mother but does not agree with her, she becomes excessively permissive toward the child and fails to nurture the child's capacity for more mature performance. On the other hand, persons perceiving themselves as superior to the mother often assume authority for decreasing or increasing developmental expectations. Conflict often arises when nursery school teachers, other teachers, or nurses in a hospital bring about abrupt changes in a child's habit training or performance.

Many problems also arise when the part-time caretaker, either consciously or unconsciously, is in rivalry with the mother for the child's affections and is in a position to be very important to the child. Generally, the younger the child, the more the balance of power over him lies in the hands of the person giving the most physical care.

While mothers generally tend to have feelings of guilt for any arrangement to share child care, the mother who perceives herself as inadequate is the most guiltridden and most susceptible to conflict arising from attitudes of rivalry and superiority in the person sharing her child's care. This is a problem of some importance in regard to ill or handicapped children. In conditions requiring a considerable period of hospital or convalescent care, mothers may gradually be made to feel that they are of little use to the child and so may eventually decrease their visiting time to the vanishing point.

This factor of rivalry versus inadequacy may be an explanation for certain more serious reactions of children to separation. Some children who have previously had poor relationships with their mothers are severely disturbed by separation when rivalry evolves. Some of them tend to forget their mothers and become attached to hospital figures. In such instances, reestablishment of the relationship with the mother is difficult and stormy. In some cases the child undergoes a regressive reaction, becoming more infantile and clinging to the mother. In some cases of older children the child and mother perceive each other as unrelated and unrewarding, and permanent separation becomes necessary. When convalescent hospital care is necessary for children because the home is inadequate for meeting the dependency needs of convalescence, there is always the danger that mother and child will tend to become more emotionally separated and the child, therefore, increasingly disturbed.

Since neonatal handicap and chronic illness are related in general to increased problems in mothering, shared child care in such cases, especially when there is considerable physical separation of child and mother, is exceptionally prone to destructive problems. The physical or psychological needs of the children involved usually obscure the basic maternal conflict and the patterns of institutional care which play into that conflict.

During the next few years, the demands of parent groups for relief from the full burden of caring for handicapped children will undoubtedly result in the creation of special day care centers, special children's hospital facilities, and more State institutional beds. Some children will come into care at a point of no return to the family. Others will come at a point when what happens to the child in care may determine whether separation will be temporary or permanent. This may well be one of the compelling crises in service to children. Programs of care which increase the existing conflict in parents are less likely to be able to return the child to his own family. Programs which are designed to share the problems of care with parents and to increase the sense of parental capacity are likely to be more beneficial to the child, the family, and the State.

Enforced Closeness

Part of a mother's ability to nurture maturity in a child is her ability to manage constructively the inevitable separating events of life, to foster the child's ability to benefit from other relationships, and to find interests and occupations for herself apart from the child-rearing task. A mother who is physically close to her child, but lacking in warmth and enthusiasm about the events of her daily life, including child care, may fail to stimulate her child to learning[4] and independence.

In young infants the excessive closeness of a mother driven by neurotic need or by deprivation in other areas of her life may result in sleep disturbances, vomiting, and diarrhea. Later, hyperactivity and learning problems may appear.

The problems arising in children from enforced or compulsive closeness are best epitomized in the school phobia. In such cases the child cannot leave the mother to attend school and, frequently, the mother cannot leave the child for minor errands, to say nothing of social engagements or work experience. Such conditions seem to have their genesis in the mother's covert wish to flee the responsibilities and binding sense of slavery in child care. This problem may be handed down from generation to generation; it has been noted that the mothers of children with school phobias have usually a history of unresolved conflict in separation from their own mothers.

In many such situations the child would be, at least, no worse off if the mother shared his care with another person in order to follow other interests. Eleanor Maccoby,[3] in a thoughtful analysis of a number of studies on the problems and attitudes of children of working mothers, concludes that the problems which arise are apt to be related to the mother's motivation for working rather than to the fact that she does work.

We are confronted, then, by the possibility that satisfying employment may enable a mother to give herself to her children more warmly and constructively than if she did not work, and that with such employment a mother has at least an equal chance as mothers who do not work of doing a satisfactory job of child rearing. A mother who is meeting more of her own needs does not place unrealistic burdens on her child. However, there is always the possibility that her feelings of guilt and inner conflict over the question of being employed will react adversely on her child's development. Still the question may be raised as to whether the harm might not be greater if she did not work.

Quite frequently the working mother must free herself from double-barreled feelings of guilt—toward her child and toward her job. In this mothers are apt to need more support from employers than they receive. In reality employers participate in the problems of part-time child care, for a mother who is in too much conflict with her child and her part-time helper will be less effective on the job. However, if the mother is in frank flight from her child care responsibilities the employer is not so likely to hear of the problem.

When a mother really cares about her responsibility for her child, the employer should recognize the essential priority of the child-rearing task. A sense of coercion toward job responsibility frequently causes excessive tension in a mother's dealing with a troubled child. Usually, this type of crisis tends to grow worse unless the mother can temporarily feel free to take as much time as she needs to deal with the difficulty at home.

Because the working mother has certain special problems it is fortunate that industry is beginning to take a look at the problem of providing the necessary elasticity for their employees who have child care responsibilities.

There are, however, sufficient adjustment problems for working mothers to make it unwise to recommend employment as a general solution to a mother's separation need. Except in cases of family economic difficulty, being relieved part of the time of the burden of child care and having diversification of interests are probably much more general needs of women than the need to be employed. A mother's feeling that child care prevents her from "doing something useful" is not identical with a need to work. When past deprivation and feelings of guilt lead a woman to feel unable to do anything except at the cost of something else, solution to the problem is difficult whether the child and mother remain together at home or are separated in some way from each other.

I have seen many children, placed in foster care because of the mother's ostensible need to work, who could not get along in foster care because of their mothers' guilt feelings.[5] The mothers constantly promised to bring their children back home without any real intention of doing so. They were unable to allow themselves to be close to their children but their defense against guilty feelings would not allow them to let the children have another significant relationship.

In some instances neither shared care nor work can solve the problem of disturbance. As Eleanor Maccoby says, "Clearly no single way of organizing family life is best for all. Some mothers should work while others should not."[3]

To this, I would add that no one pattern of shared care is effective in meeting problems of conflict arising from enforced closeness of mother and child. The interests of the affected parents and children will be better served when the community offers a number of types of service each corresponding to a particular type of need. A clear diagnosis of each situation involving disturbed mother-child relationships then becomes important in order to match the service and the individual need.

Special nursemaids or homemakers are unlikely to be effective in situations requiring care of extremely disturbed children. Children in need of psychiatric inpatient care do not respond well to the care of foster parents. Part-time work for the wife is seldom the entire solution to sexual and marital maladjustment. Adolescent babysitters are seldom successful in disciplining children with severe conduct disorders. A mother's efforts to find values in volunteer work will not necessarily make her clear about how to deal with her adolescent daughter.

The problems of certain families today indicate a need for more social support for the shared care of children and more balance between separation and closeness in the child-rearing task. In some families these needs will be met by helpers coming into the home. In others some form of special day care may better meet the need. In some instances shared care and maternal employment is a good solution. In many cases of parent-child distress a more enduring separation may be the best answer. It is sometimes better for a family to break up completely than for people to stay together who are becoming more and more disturbed.

Some mothers who are too close to their children and uncertain in caring for them may benefit from cooperative nursery activity where they can compare their efforts and their children with those of others. Other parents who are troubled about limits and values for adolescents may derive help by getting together in groups through which they in a sense may share the risks of child development.

The individual personality development of children proceeds more healthily when the process is determined by multiple influences as well as the central mother-child relationship.

The value of any service may be nullified if it is inappropriate or unrealistic. The widespread beliefs that family unity should be preserved at all costs or that working mothers' children are neglected and delinquent children are overgeneralizations. The solution to each problem of disturbance in children must be determined by the pattern of maternal capacity and incapacity, and by the degree and nature of difficulty in the child.

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The important thing is not to get worried about everyday frustrations. Life is full of frustrations and there's no reason to be disturbed by this simple fact. People are probably more hurt by worrying about getting frustrated than they are by actually being frustrated and acting accordingly.

Byron Hughes, professor of child development, University of Michigan.

A sociologist compares 19th- and 20th-century life in America and finds some . . .

CONSTANT VALUES IN AMERICAN SOCIETY

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IT SEEMS to me that in many areas of American society there has been less change over the past century than many people believe.

I do not mean to imply that our society is basically static. Clearly, there have been great changes—industrialization, bureaucratization, and urbanization—which have profoundly affected other aspects of the social structure. There have been changes in work habits, leisure, personality, and family patterns. But concentration on the obvious social change in a society that has spanned a continent in a century and moved from a predominantly rural to a metropolitan culture tends to obscure what has been relatively constant and unchanging.

Two basic values, equalitarianism and achievement, are dominant in American culture, and they are now as they have been in the past expressed in various institutional structures. Though they have certain contradictory features, neither seems to be weakening. The value equalitarianism still largely determines the nature of our status system; and, in spite of dire predictions that the growth of large corporations has meant a decline of upward mobility and a consequent fall in achievement motivation, American society is still characterized by a high level of actual achievement in the population as a whole.

Equalitarianism

The feature of American life which most impressed the foreign travelers in the 19th century was the way in which Americans behaved toward each other. A summary of the writings of hundreds of British travelers in America before the Civil War reports:

> Most prominent of the many impressions that Britons took back with them [between 1836 and 1860] was the aggressive egalitarianism of the people.[1]

Frances Trollope, visiting in America in 1830, complained about the "coarse familiarity, untempered by any shadow of respect, which is assumed by the grossest and the lowest in their intercourse with the highest and most refined." [2]

In 1837 Harriet Martineau, a sympathizer with republican institutions, found the same phenomenon but evaluated it quite differently:

> Nothing in American civilization struck me so forcibly and so pleasureably as the invariable respect paid to man, as man.[3]

Similar observations were made by the two best-known foreign commentators on 19th century society, Alexis de Tocqueville [4] and James Bryce.[5]

What impressed the typically upper class European travelers in the past has also deeply affected the high status Europeans who have come to America in recent years. One observer has commented:

> With his deep sense of class and status, integration in American society is not easy for the émigré. . . . I met several young Croatian doctors in the Los Angeles area who were earning $25,000 to $35,000 a year, but still felt *declassed.*[6]

An eminent sociologist at one of the leading universities in the Communist world when asked at a private gathering what in America most surprised

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Condensed from a paper presented at the 1959 forum of the National Conference on Social Welfare.

him as compared with his expectations replied without hesitation: "Equality. There just is no country in Europe, Communist or capitalist, in which men treat social inferiors with as much respect, and in which inferiors show as little fear of those higher than themselves."

The strength of equalitarianism may be seen in the internal structure of many other institutions such as the family and the school. For example, reports of pre-Civil War British travelers were almost unanimous in commenting on unique patterns of the American family in terms which read like contemporary analyses:

> The independence and maturity of American children furnished another surprise for the British visitor. Children ripened early. . . . But such precocity, some visitors feared, was too often achieved at the loss of parental control. Combe claimed that discipline was lacking in the home, and children did as they pleased. . . . The child was too early his own master, agreed Mrs. Maury. No sooner could he sit at a table than he chose his own food; no sooner speak than he argued with his parents. Bad as this might be, countered Thomson, American children were still far more affectionate and respectful towards their parents than was true in British poor or middle-class families. Children were not whipped here, but treated like rational beings.[5]

Harriet Martineau's report on child rearing in Andrew Jackson's day also sounds contemporary:

> My friend observed that the only thing to be done [in child rearing] is to avoid to the utmost the exercise of authority, and to make children friends from the beginning. . . . They [the parents] do not lay aside their democratic principles in this relation, more than in others. . . . They watch and guard: they remove stumbling-blocks: they manifest approbation and disapprobation: they express wishes, but, at the same time, study the wishes of their little people: they leave as much as possible to natural retribution: they impose no opinions and they quarrel with none: in short, they exercise the tenderest friendship without presuming upon it. . . . the children of America have the advantage of the best possible early discipline; that of activity and self-dependence.[6]

What struck Harriet Martineau as progressive was interpreted differently by Anthony Trollope:

> I must protest that American babies are an unhappy race. They eat and drink just as they please; they are never punished; they are never banished, snubbed, and kept in the background as children are kept with us.[7]

Another Englishman's description of New York schools in 1833 also has a contemporary ring:

> The pupils are entirely independent of their teacher. No correction, no coercion, no manner of restraint is permitted to be used. . . . corporal punishment has almost disappeared from American day schools; and a teacher who should now have recourse to such means of enforcing instruction would meet with reprehension from the parents, and perhaps retaliation from his scholars.[8]

This emphasis on equalitarianism as a dominant feature of American values and behavior, past and present, is seemingly contradicted by the widespread existence of status differences. The American value system has never denied existing differences in rank and authority. But as Alexis de Tocqueville and others noted, Americans believe that such differences are accidental, not essential attributes of man, which it is not good taste to emphasize publicly.

Achievement

Achievement, as a dominant value, shown by Americans' efforts to improve their lot in life and by the belief that the most able should be rewarded by high position, is also strongly rooted in American society. It may, in fact, be a necessary concomitant of the stress on equality. Thus Americans as compared to Europeans are more willing to acknowledge their lowly origins. This enables the man of humble birth to regard upward mobility as an attainable goal for himself or his children; while it has fostered in existing elites the persuasion (however mistaken) that their eminence is the result of individual effort.

Though there does not seem to be more social mobility in the United States than in Western Europe, in America the modest social origins of men of prominence are given widespread publicity, while comparable backgrounds in Europe are more likely to be conveniently forgotten. A recent study of social mobility in France reports that "it is precisely among those who have experienced the greatest social mobility that reticence [in the interview] may be of the most significance."[9] Similarly, British corporation directors have been found to be less likely than American executives to report menial jobs in their career histories.[10]

But even in a completely egalitarian society, only a few can reach the top of the ladder. What is more important for the average person are his experiences with and consequent perception of more modest opportunities for social mobility: the extent to which he sees sons of manual workers and poor farmers becoming teachers, government officials, engineers, clerks, and businessmen.

The most constant source of social mobility throughout American history has been the recurrent waves of mass immigration which over the years brought the depressed strata of other lands to fill vacancies at the bottom of the social structure, thus enabling native-born Americans to rise. The early pre-Civil War foreign travelers in America were struck with the fact that "it was left to the free Negro, the Irish immigrant, and to a lesser extent the Chinese 'coolie' (in California) to be the hewers of wood and the drawers of water."[1]

If the immigrants felt aggrieved with their position in the New World, their lot was materially better than it had been in Europe, so that they could think of their situation as an improvement even though they were at the bottom of the social ladder in this country.[11]

If mass immigration has contributed to the existence of widespread social mobility and the perpetuation of the American value system, then it may be asked why its ending after World War I did not reduce mobility, and give rise to a native American working class which would have less faith in the "promise of America." The answer probably lies in two factors: (1) the changing character of the occupational distribution, as more of the total labor force is employed in higher paid and higher status white-collar, professional, and managerial positions; (2) the replacement of immigration from Europe with migration to the industrial centers from "underdeveloped" parts of this continent—of Negroes, Puerto Ricans, Mexicans, French Canadians, and "poor whites" from the rural South.

These ethnic groups, which comprise over 20 million people, earn a disproportionately low share of the national income; they have little political power, and no social prestige. Many of them live in ethnic neighborhoods and have little social contact with native white Americans higher up on the social scale. The recent "flight" of middle-class whites from cities to suburbs is but a recent example of a longtime pattern of similar flights from areas of immigrant settlement. The only difference today is that color as well as ethnicity is involved.

As in the past, there are now two working classes in America, an upper skilled level composed largely of native white Americans, and a lower less skilled one composed largely of Negroes, Mexicans, and Puerto Ricans. The social and economic cleavage between them diminishes the chances for the development of solidarity along class lines.

Despite the deprivations experienced by immigrants and minority groups, thus far each group entering the system has been able to move up. In late 19th century America there was a strong occupational differentiation between Catholics and Protestants. Catholics were largely immigrants in manual occupations, while Protestants were mostly native born and thus in relatively high status jobs. But today Catholics whose families have been in this country for three generations show no difference in occupational structure as a group than white Protestants of comparable background.[12]

While the Negroes, Puerto Ricans, and Mexicans have a long way to go to achieve the status of descendants of European immigrants, there is evidence that they too are on the road upward economically as well as legally and socially.

Consequences of National Wealth

The emphases on equality and achievement in the American value system have been perpetuated by our increasing national wealth.

Through industrialization and advancing technology America in the latter part of the 19th century became the wealthiest country in the world, a position it has never relinquished. Between 1869 and 1953, per capita income (standardized to 1929 prices) rose from $215 to $1,043.[13] As the size of the national income has increased the distribution of consumers' goods has tended to become more equitable. This in turn has considerable effects on patterns of class relations.

Gideon Sjoberg has pointed out that with increasing national wealth has come a great gain in the income of manual workers relative to the incomes derived from many middle-class occupations. And he argues that with a rise in relative income status manual workers have achieved a rise in social status as well. The status difference between skilled manual workers and at least the lower sections of the middle class has become less well defined, since manual workers like middle-class people have been able to purchase goods which confer prestige on the purchaser—clothing, cars, homes, and television sets.[14]

Such improvements in income and style of life undoubtedly help to preserve the belief in equality of opportunity. A manual worker who can buy his own house, or a new car, will feel that he has moved up in the world even though he has not changed his occupational position.

To some Europeans, different classes mean distinct ways of life with little overlapping of the goods they own or can afford to purchase, even though in many European countries rates of individual mobility across class lines may be quite high. The greater the inequities, the more the upper classes have the need for a rationalization of their claim to privilege. In part, this need becomes resolved by a value system which defines the lower classes as congenitally inferior and worthless.

In America, by contrast, the mildness of differences in distribution of consumers' goods enables the wealthy and poor alike to see differences among the classes as relatively unimportant, reflecting differences in rewards for greater ability or luck, and encourages many to feel that they can improve their lot.

Effects of Mass Education

The strong and continuing interest of Americans in equality of opportunity is perhaps nowhere as vividly expressed as in the constant pressures to expand educational opportunities. Since the winning of the fight for free public schools before the Civil War, there has been a steady growth in school attendance at primary, secondary, college, and adult levels. By 1954 more than half of all high school graduates continued their education. Today about 1 in 4 of those in the college age group (18 to 21) are attending college, compared to 1 in 25 in 1900.[15]

Today college teachers are not only the fastest growing major profession, but now far outnumber lawyers, physicians, dentists, clergymen, and military officers.[13] These data belie the contention that Americans are not willing to pay for education. In fact, the percentage increase of expenditures on education by American consumers in the period from 1935 to 1948 was far higher than the percentage change in all other categories of consumer expenditure.[13]

In providing opportunities for education America far outranks every country in the world. This means that a large proportion of our young people have the formal prerequisites to achieve the highest positions in society. Over 30 percent of college students in the United States are the sons of manual workers.[16]

The gradual equalization of educational opportunities in America has reduced the previously marked discrepancy between the educational attainments of manual and nonmanual workers. Today high school graduation has practically become the working-class norm.

Mass education has also had effects on the quality of education. The notion is common today that the strictness of past educational methods resulted in a superior output. But present-day students do as well or better than past generations on comparable examinations in the same subjects even though the schools have been serving increasing proportions of students from lower cultural backgrounds and of less intellectual aptitude.[17]

Mass education has also resulted in raising the level of taste and culture among the population. Recent years have brought an extraordinary rise in the sales of classical records, a growth of "serious" radio stations, a shift in paperback book sales from "lowbrow" to "highbrow" literature, and the emergence of more than 100 literary magazines, 1,100 community symphony orchestras, and much greater numbers of little theater groups.

Sociological and public opinion research indicate that education is also a liberalizing force which may be bringing about increasing national consensus on questions of public policy, since increased education is highly correlated with support for equal rights for ethnic minorities and civil liberties for dissident political views.[18]

Change in Family Patterns

The theory that our society's dominant values continue to be equality and achievement are supported by certain patterns and trends in family life: the relative weakness of parental authority; child-centeredness (reflecting the orientation toward future achievement); a decline in the "double standard" of sexual behavior; the growth of equality in husband-wife relations; the ever increasing proportion of married women who work. However, some recent changes in family behavior do not seem to confirm this assumption, at least within the family.

Perhaps the most surprising change is the rise in the birth rate. Demographic experts had expected in the later postwar years a continuation of the long-term decline in the birth rate which has been characteristic of all developed industrial societies. The crude birth rate had jumped from a low of 16.6 per 1,000 in 1933 to 25.8 in 1947, reflecting the deferred "demand" of the war years.[19] But instead of dropping sharply from this high figure as was anticipated, birth rates have continued to run at about 25.0 during the past decade.[20]

The earlier decline in the birth rate had been explained in part by the thesis that since the intimate obligations of family relations hold people back in occupational success, there will be a strong tendency in an achievement oriented society to restrict the family to the smallest possible unit consistent with the performance of the major function of producing and socializing the young.[21] The "baby boom" of the fifties does not fit into this thesis. Perhaps, the earlier pattern of restricted family size involved serious strains which induced a reversal of the trend, for a solidary family group provides the social intimacy and psychic security needed for personal stability. Moreover, increasing wealth and the fact that movement up industry's bureaucratic ladder does not require the accumulation of personal savings have lessened the conflict between occupational and family requirements in middle-class families.

Demographically speaking, the recent increase in fertility has been produced by a number of factors: Americans are getting married at younger ages,[22] more people are marrying at some time in their lives; the number of families having three and four children has increased.

Birth rates have increased more among the better educated groups than among manual workers. While the lower status groups are still producing more children than the middle classes, higher status individuals are contributing a much larger share of today's offspring than they did in the past. A study made during the depression found that among families who deliberately planned for each child a large family size was correlated directly with higher income, occupational status, and education.[23]

The trend toward a more familistic culture in the United States is also reflected in the stabilization of divorce rates. In 1900 there were 4 divorces for every 1,000 married women over 15. Although by 1946 this rate had climbed to 17.8, there has been a steady decline in the divorce rate since the peak reached at the end of the war. This had fallen to 9.2 in 1957, still the highest for any major country in the world but almost down to prewar levels.[20]

By-Products

Many problems in American life which are the source of considerable anxiety and controversy may actually be concomitants of an egalitarian and achievement orientation. For example, the same patterns of status distinction which some people regard today as evidence of the decline of equalitarianism were reported by various foreign travelers in the 19th century. Some of these observers regarded Americans as more status conscious than Europeans and suggested that this was the result of a lack of a well-defined deference structure in which there is no question about social rankings.

The great concern with family background (which generation made the money?) that observers from Harriet Martineau to Lloyd Warner have shown to be characteristic of parts of American society may be a reaction to the feelings of uncertainty about social position engendered in a society whose basic values deny anyone the legitimate right to claim higher status by birth than his neighbor.

The problem of conformity which so troubles many Americans today has also been noted as a major aspect of American culture by observers from Alexis de Tocqueville to David Riesman. Such analysts have repeatedly stressed the extent to which Americans are sensitive to the judgments of others. Never secure in their own status, they are concerned with "public opinion" in a way that aristocrats do not have to be. Harriet Martineau almost seems to be paraphrasing Riesman's own description of today's "other-directed" man[24] in her picture of the early 19th-century American:

> Americans may travel over the world, and find no society but their own which will submit [as much] to the restraint of perpetual caution, and reference to the opinions of others. . . . where the youth of society determines in silence what opinions they shall bring forward, and what avow only in the family circle . . . and where elderly people seem to lack almost universally that faith in principles which inspires a free expression of them at any time, and under all circumstances.[3]

In a situation of "status anarchy," when people are encouraged to struggle upward, but in which there are no clearly defined reference points to mark their arrival and where their success in achieving status is determined by the good opinion of others, this kind of caution and intense study of other people's opinions is natural.

A society which emphasizes achievement and which resists status claims based solely on ancestry must necessarily be a society in which men are sensitively oriented toward others. And precisely as we become more equalitarian, as more people are able to take part in the status race within the large industrial bureaucracies of the impersonal metropolises, so we become more American in the Tocquevillian sense.

The same point may be made in regard to much of the discussion about the negative consequences of mass culture. Increased access by the mass of the population to the culture market necessarily means a leveling of cultural taste as compared with a time or a country in which only the well-to-do and the well-educated have access to the creators of culture. The "Americanization" of European culture, which disturbs so many European intellectuals, may reflect not the power of American dollars but rather the Americanization of the class structure of Europe.

Many in this country who believe in equalitarianism would also like to secure some of the attributes of an elitist society. Today perhaps we need to remember the maxim that you cannot have your cake and eat it too. You cannot have special public schools for the elite in a society which stresses equality; you cannot produce for a cultural elite without regard to public opinion and mass taste in a society which emphasizes the value of popular judgment; you cannot have a low divorce rate and an end to differentiation in the roles of the sexes; you cannot expect to have secure adolescents in a culture which offers no definitive path from adolescence to adulthood.

But we are not necessarily in a vicious circle. In fact, there is considerable evidence to suggest that higher education, greater economic security, and higher standards of living result in strengthening the level of culture and democratic freedom. The market for good books, good paintings, and good music is at a high point in American history. There is evidence that tolerance for ethnic minorities is also at a high point. More people are receiving a good education in America today than ever before. Many people, to be sure, buy good paintings, records, books, or well-designed furniture in order to "keep up with the Joneses," but this means that their children will grow up in homes in which good taste is part of the environment.

I would like to emphasize again what most of the foreign travelers to 19th-century America took for granted: that this country has been the most radical Nation on earth in terms of social relationships. American cultural radicalism consists of breaking down the barriers of class, of inherited background, and opening the doors of real culture to the entire population.

I do not predict a coming egalitarian and cultural utopia. Some of our values will always turn out to be incompatible. As we cope with various problems, we create others. But problems and conflict and even despair are the lifeblood of democracy.

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The childhood shows the man
As morning shows the day.
John Milton in Paradise Regained, IV

An important process in treatment in a mental retardation clinic is . . .

COUNSELING PARENTS OF RETARDED CHILDREN

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IN ALL SERVICES directed at helping children, treatment necessarily includes, besides the child, another person who is directly responsible for the child and closely affected by his condition. This person is usually the mother, and though not a patient, is always a client of the agency. This is particularly true in clinics concerned with mental retardation. Treatment of mentally retarded children has to be primarily aimed at reduction of secondary difficulties and improvement in tolerance of the condition and in ability to handle it on the part of the persons carrying responsibility for the child. The problem of retardation is always a family problem, and diagnosis has therefore to be a family diagnosis focused on the total situation. Thus, parent counseling becomes one of the most effective treatment tools.

"Parent counseling" is used here primarily to describe a process of casework treatment, based on diagnostic findings and aimed at ego support and adjustment to reality. It is an enabling and helping process based on the understanding of the dynamics of personality and it uses relationship as a vehicle.

"Diagnosis" as used here will include medical, social, and psychological diagnosis of the child's condition, of the needs of the family as a unit, of the parents' personalities, and of their ability to use available services.

Many of the problems that occur in connection with mental retardation are common to families of handicapped children in general. The parents have to understand the nature and extent of the child's condition, face their own feelings of guilt and rebellion, and learn adequate modes of handling the afflicted child. In such families other children may be neglected and normal life experiences curtailed for either the healthy or the handicapped members, or both. Family breakdown may result from the parents' own withdrawal from normal activities. In the family with a mentally retarded child additional factors of social shame, embarrassment over the child's behavior, and bafflement over the child's uneven capacities, often must be dealt with.

In contrast to other medical conditions, treatment of the retarded child's condition rests primarily with the parents rather than with a professional worker, even if the youngster attends school or a day care center. It usually consists of helping the child to achieve optimal development and maximum use of his capacities. To do this effectively parents need help in working through their own feelings and adjustments as well as practical advice in regard to their everyday problems.

Relationship and Timing

Development of a good professional relationship is one of the main prerequisites for successful work with parents. Parents tend to reject painful information that comes from a seemingly uninterested or unfeeling source. If the diagnostic process in the clinic is an unhurried one, parents have time to understand step by step what the clinic personnel are attempting to do, to prepare themselves to accept the diagnosis and a treatment plan, and to develop a workable two-way relationship with the clinic personnel based on trust and respect. Much of the frantic "shopping around" in connection with chronic conditions may be caused by attempts on the part of clinicians to shortcut the diagnostic processes. The team approach in diagnosis gives the parent an opportunity to work through negative feelings that emerge in one or the other contact and to clarify interpretations. "Shopping around" can often be avoided by permitting parents to use the various team members for comparison of opinions.

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Parents' previous experience with other facilities have to be dealt with directly at the time of first contact. If the new clinic does not want to be just one of a growing list of clinics in the parents' experience, client and workers must clearly understand the reasons for dissatisfaction with the previous agencies and what the client's present expectations are.

At the Mental Retardation Unit of St. Christopher's Hospital for Children the diagnosis may extend over several weeks. The clinic is staffed by a team representing a variety of professional disciplines. Cases are screened for admission by the pediatrician and most of the team members are involved in the diagnostic work-up. This is terminated by a team conference in which plans are worked out with full consideration of the child's needs, family wishes, and available facilities. The team delegates discussion of such plans with the family to the person who has developed the most workable relationship with the family and who will have to carry the main responsibility for helping them carry out or modify the suggested plans. This is frequently the social caseworker.

In regard to mental retardation there is sometimes a strange notion that establishing diagnosis is identical with giving treatment. Diagnosis is an essential step toward understanding treatment needs, but it is not treatment. The parents' expectancy and readiness for help is necessarily being aroused during the diagnostic process. If this is not followed up promptly with an actual treatment plan, their readiness to involve themselves in a treatment process may be lost.

The parents' most crucial need for service occurs at the time when they first learn of the diagnosis. It is then that they need support in handling their emotions, help in clearly understanding the diagnosis and its implications, and assistance in planning for their child.

Considerable anxiety is usually aroused by a diagnosis of mental retardation. If this is not handled promptly, parents may develop rigid defenses which are not easily amenable to change. A caseworker can help parents set up the kind of defenses that will cushion reality adjustment rather than paralyze functioning. Even the most stable parents have to cope with a certain amount of personality disorganization in reaction to severe stress and shock. Professional casework services at this point work as a "catalyst" for helping parents to recognize their thoughts and reestablish ability to function.

Casework Approach

The parents who come to a mental retardation clinic are as a rule quite aware of the fact that they have a problem. They may, however, deny its nature. Parents should clearly understand the findings of the clinicians in regard to their child's difficulty. However, they need not accept these findings immediately and fully in order to work toward relief of their problem. Diagnosis of mental retardation is not likely to change, and the parents' acceptance may come gradually as a result of treatment.

If a parent persists in calling his child "slow" instead of retarded, the worker may do the same. If the parent continues to express conviction that the child will eventually "catch up," or does not belong in this "terrible" special class, the worker need not contradict him but can patiently help him face the truth. Parents can be helped gradually to see the diagnosis not as a "dead end" verdict, but as a starting point from which to approach much of the problem.

Parents often spend considerable effort in trying to prove to the worker that the child is normal. If they really believed this, they would not continue with the clinic. They often try to push the worker into an argument in order to convince themselves. The worker does well not to be drawn into such an argument. In time the parents draw their own conclusions.

We found most of the parents seen at our clinic very eager to find and use services. Many cooperate far beyond their own need and show good grasp of the value of their contributions to the understanding of the problem. However, as in any clinic setting, some parents withhold information or try to manipulate clinic personnel and time. Such behavior has to be discussed quite directly with the clients and limits should be set.

Service cannot be effective without the full and voluntary participation of parents. The parent who cannot respond to efforts to help him and who continues to try to manipulate the clinic will manipulate treatment goals. Neither he nor the child will in the end profit from treatment. However, the amount of responsibility for initiation and continuation of contact that can and should be put on the client should be determined on the basis of the psychosocial diagnosis rather than on rigidly established clinic procedures.

Through social-casework counseling, parents of retarded children can be helped to develop:

1. Some understanding of the meaning of the term "retarded" as it applies to their child.

2. Understanding of the degree of their child's handicap and what this will mean in the future.

3. Ability to understand their child's assets, his needs, and his difficulties.

4. Appreciation of the effect the presence of a handicapped child has on family life in general, on their other children, and on themselves as parents, and on adjustment of the family within the neighborhood.

5. Understanding of the fact that the child's retardation and his behavior are separate entities and that behavior can be influenced at least to a degree by educational approaches.

6. Ability to judge whether neighborhood reactions are caused by the child's behavior, appearance, or mental ability.

7. Techniques to use such understanding constructively in order to help the handicapped child, the entire family, and the community.

8. Knowledge of available resources relating to their own situation and to the problem of retardation in general.

While needs differ, time for consideration of these areas has to be provided in planning. The "one shot" approach is rarely helpful.

Patterns in Counseling

In spite of the uniqueness of each case, definite patterns emerge that may serve to guide program planning. Contacts fall roughly into four phases: (1) *the initial period*, encompassing the diagnostic process, clarification of the situation and needs, establishment of treatment goals, and selection of treatment methods; (2) *treatment*, consisting of more or less intensive counseling, individually or in groups; (3) *tapering off*, a time when goals being achieved, contact becomes less frequent and is eventually stopped; (4) *followup*, consisting of occasional contact either as needs arise or as children are brought to the clinic for other appointments.

Initial period. It is neither feasible nor necessary to offer counseling services to all parents who come to a clinic for diagnosis of their child. By the end of the diagnostic period it should be possible to estimate fairly accurately the parents' need for counseling services, their amenability to this type of service, and the feasibility of intermediate as well as long-range goals.

Selection of appropriate treatment methods should be made after consideration of a number of factors:

1. *Ego strength*—the parents' maturity; emotional stability; capacity to accept their roles as parents, as marital partners, as members of their community; their intellectual endowment and the use they make of it.

2. *Family strength*—the quality of interrelationships between the different members of the family, and the kind of emotional and practical support parents can count on from other family members.

3. *Environmental and cultural influences*—the presence or absence of other irritants in the home or in the neighborhood and the influence of cultural and religious factors on the family's acceptance or rejection of the problem.

4. *Degree of handicap* and the parent's understanding of it. It is considerably more difficult for the parents of a moderately retarded child who is physically healthy and attractive to accept the diagnosis than to see him as plain stubborn, lazy, or spoiled. The parent of a severely retarded child with external stigmata is less able to avoid the problem.

Treatment goals. In mental retardation, treatment is aimed at increased comfort of all people concerned with a trying situation.

Problems have to be analyzed so that partial solutions can be found as the need arises. Tension and frustration in parent and child may be reduced by cathartic experiences for the parents, and by help with practical problems such as learning ways of handling unacceptable behavior, and planning for school or other types of placement. If problems are met as they occur, many retarded children can live happily within their own family groups and make their contributions to family living, at least during their childhood years. Where placement away from home is indicated, the parents can be helped to see that this has advantages for the handicapped child as well as for the rest of the family.

Level of Treatment. In general, the level of treatment remains in the area of reality adjustment, ego reintegration, and development of techniques for daily living. Intensity and depth of treatment vary greatly within the range of clinic function. If the parents have prominent personality disturbances or many problems in addition to their child's retardation, they may have to be referred to more appropriate agencies.

Treatment Techniques. Treatment techniques most often used are clarification, supportive counseling, and environmental reorganization. This does not preclude the use of insight therapy, but where such therapy is of paramount importance, referral becomes necessary. Though the counseling focuses on the problem of mental retardation, parents may be enabled by treatment to translate the help they get for one problem to others as needed. This happened in the case of the A family.

The A's were referred by their family physician, who was struck by the intensity of the negative parent-child relationships. The oldest child, Tim, retarded because of an organic condition, was extremely hyperactive and lacked concentration. The parents' severity in trying to control his behavior had led to violent negativism on his part. The younger brother, Don, considerably brighter than Tim, got vicarious enjoyment out of teasing his older brother into temper outbursts resulting in actions for which Tim eventually was punished.

During the contact here, explanation as to the organic basis of some of Tim's behavior was given to both parents. They were helped to evaluate their own approach to the children, to consider the differences of their children's needs, and to try new ways of meeting these needs.

The parents became aware of the teasing of the younger child and of the effect on both children of their own impatience and high standards. They also became aware of their own strained relationships and how these resulted in their undercutting each other's effectiveness with the children. Gradually the whole family situation calmed down. When a new baby was born, both parents were able to avoid many of the mistakes they had made at Don's birth which had created such intense jealousy and difficulties between the boys.

Treatment Methods. The caseworker may counsel either in individual contact or in groups. It has been hoped that the development of group techniques might prove more economical of the worker's time than individual contacts. This has hardly been the case as far as economics of time and professional efforts are concerned. The economy lies in the fact that the more appropriate treatment is the more effective one.

Individual Counseling

At the St. Christopher's clinic individual counseling has been offered to the parent with highly individualized needs, strong emotional dependency, intense masochism with certain types of passive-aggressive adjustment, or clearly psychotic tendencies. We found such parents poor group risks, since they tend to be disruptive to group processes because of their urgent need for attention, the intensity of their relationships, or their need to act out. In individual contact the worker can adjust the process to the individual and can control the gratification of his particular needs. This was the method used in the B case.

The B's had accepted the diagnosis of their only child's retardation before coming to the clinic, but they felt strongly resentful of the doctor who had given the diagnosis. They interpreted his statements as meaning that no limits could be set for the boy's behavior. They joined a parents' organization and used the group to project their anxiety about their own problem.

In individual contact, the B's were brought back again and again to their own problem of handling their child's behavior. They were helped to face their misinterpretations of what they had been told. They also came to realize how much they acted out their own discouragement by proving time and again that they were not able to set limits for their child, while other people were able to do so. As it became necessary, the caseworker allowed them to forgo discussion of the child and his problem and focus on their general discouragement and disappointment, of which the child was only one factor.

The caseworker saw the parents in separate interviews and helped them work through some of their rivalry in their positions within the family so that a common approach could be established.

Group Counseling

In group counseling we are not concerned with intensive group therapy, but with casework counseling in groups. Goals are: personality reintegration and adjustment to reality. Group processes and teaching methods are combined to afford the individual relief from tension, understanding of children's behavior, and techniques for handling specific problems.

Group processes are helpful to basically mature parents whose functioning is temporarily impaired by the overwhelming nature of their problem; to parents with a tendency toward projection and intellectualization; to parents with pronounced though well-controlled feelings of hostility, who can find relief through limited acting out; and to parents with dependency needs which may be met through group identification and support.

In selecting members for groups at St. Christopher's we have not found it particularly necessary to strive toward homogeneity of social strata, intellectual capacity, personality makeup, or degree of defect in the members' children.

Groups soon develop a homogeneity of their own, the members becoming quite supportive of one another.

The case of Mrs. C. illustrates several of these points.

Mrs. C. was unable to make effective use of individual contact when it was offered. She covered up her intense feelings of hostility by complete denial and adopted an attitude of submissiveness. In the group she quickly assumed a certain amount of leadership, which the group kept from going beyond bounds. She used the group constructively to gain better understanding of her own problems, to learn from other parents techniques of handling situations, and to get gratification for her need to dominate.

After the series of group sessions ended, a second attempt at individual counseling, made at Mrs. C's request, was no more effective than the first. But in another series of group sessions she again used the group experience constructively.

Length of Contact

Length of time necessary to achieve intermediary or long-range goals varies greatly, depending on the kind of emotional or reality problems to be worked out and the complications encountered in the process. Length of contact may be in inverse ratio to the severity of the actual handicap. An obviously severe handicap often allows for clearer diagnosis, less parental resistance, and fewer alternatives. On the other hand, parents of a more salvageable child may be in need of longer periods of service to achieve an acceptance of the retardation and evaluate a variety of possibilities for the child.

At the St. Christopher's clinic cases that receive *short-term services* only fall roughly into three groups.

Group 1 includes parents who during the diagnostic process or previously have learned to understand and accept their problem and are basically able to handle it on their own. Usually only one interview following the diagnostic period is needed to clarify that the clinic stands ready to help them whenever necessary. Such parents use the clinic as needs arise.

Group 2 includes parents who are not accessible to continued treatment even if they are in need of it. They either have not accepted the diagnosis or are unable to mobilize themselves sufficiently to involve themselves in treatment. The caseworker alerts other team members to these problems so that the parents may receive some help when they bring the child in for followup visits to the physician or the psychologist and may be referred to the caseworker at a later date if feasible. In the interim the caseworker seeks opportunities for casual contact with the parents in the clinics.

Group 3 includes parents already known to community agencies, which usually continue service to the family, often in collaboration with clinic personnel.

Intensive casework treatment over a longer period is offered parents with complex problems either of their own personalities, environmental situations, or difficulties with the child. We have found it most economical and helpful to offer intensive, frequent interviews at the very beginning of the treatment period and then to gradually decrease contacts as parents become able to manage on their own.

Recently we have begun to experiment with a more extensive than intensive approach consisting of a cooperative effort between the public health nurse and the social worker. Two groups of parents have been included in this program: (1) basically stable parents whose problems of child management are caused by the child's severe handicap; (2) immature, anxious parents who have management problems with their children caused at least in part by their own insecurity. No attempts are being made with either group toward too strong involvement in the parents' own problems. Explanations are given for the child's behavior and new approaches to handling are suggested. The public health nurse visits the more immature parents to demonstrate ways of handling the child. It is too early to say how helpful such an approach may be. However, considerable relief of upset has been achieved in a few of the families in this experiment.

All tapering off of long-term treatment should be on a planned basis. Unplanned "fizzling out" devaluates the treatment received and may leave the parents with a feeling of dissatisfaction. As treatment goals are gradually realized, parents themselves usually begin to express a lessened need for contact. Increase in problems and anxiety may occur as wider spacing of interviews begins. If the caseworker permits the parents to set their own pace, the frequency of contacts will decrease.

One advantage of casework at a clinic is that cases can be followed over extended periods of time without maintaining intensive or regular contact. Parents often use scheduled followup visits to the pediatrician, psychologist, or speech pathologist as opportunity to bring the caseworker up to date with their present stage of affairs. The caseworker also may schedule followup interviews at certain stages in the child's life, for example when he is getting ready for a nursery school experience, camp experience, or school placement.

Parents' Organizations

Parents' organizations such as the Association for Retarded Children should be used as a resource in planning with parents of mentally retarded children. These organizations provide such parents with strong emotional support and valuable outlets for the constructive channeling of their anxieties, frustrations, and tensions. However, referrals to such groups should be made on the basis of diagnostic considerations, and should include preparation of the client and the organization as in any agency referral.

The timing of such a referral is important. These organizations properly expect their members to promote understanding of the problem of mental retardation. To do this effectively and without harm to themselves parents have really to understand and accept the nature of their own problem and they have to be ready to identify with a large group. Otherwise they may use activity in the organization to avoid facing their own problems and working through their own anxieties and difficulties. We have found that parents who have joined large organizations of parents without preparation often accept mental retardation as a community problem, but do not really acknowledge their own problems in relation to their own mentally retarded child.

Parents who are well prepared for group membership can offer a great deal to these organizations in their work to spread understanding of the needs of the mentally retarded.

However, this type of activity cannot substitute for the emotional and practical help needed by parents at crucial points to maintain their own and family stability in facing the problems presented by the fact of their child's retardation. In offering such help, the goal of casework counseling, whether to individuals or groups, is to help parents achieve their optimum functioning to meet their own responsibility for the treatment of their child.

Guides and Reports

BEHAVIOR PROBLEMS OF CHILDREN IN NAVY OFFICERS' FAMILIES as related to social conditions of Navy family life. Genevieve Gabower. Catholic University of America Press, Washington 17, D.C. 1959. 279 pp. $3.

A social work study of the effects on children's behavior of such conditions as family moving, separation from the father, and community attitudes toward the Navy family.

DELINQUENT BEHAVIOR; culture and the individual. William C. Kvaraceus and Walter B. Miller, with the collaboration of Milton L. Barron, Edward M. Daniels, Preston A. McLendon, and Benjamin A. Thompson. National Education Association of the United States, 1201 16th Street N.W., Washington 6, D.C. 1959. 147 pp. $1.25. Discounts on quantity orders.

Presents concepts intended to help school workers plan and carry out practices for dealing with delinquency. Prepared by a psychologist, a cultural anthropologist, a sociologist, a psychiatrist, a pediatrician, and a criminologist.

A REVIEW OF RESEARCH ON PARENT INFLUENCES IN CHILD PERSONALITY. Rita V. Frankiel. Family Service Association of America, 215 Fourth Avenue, New York 3, N.Y. 1959. 32 pp. 65 cents.

Surveys highlights of multidisciplinary research literature on effects on children of specific infant-care practices, of general patterns of parent behavior and motivation, and of parent attitudes.

RESPONSIBILITIES OF STATE DEPARTMENTS OF EDUCATION AND HEALTH FOR SCHOOL HEALTH SERVICES; a policy statement. Revised 1959. Approved by the Council of Chief State School Officers and the Association of State and Territorial Health Officers, Washington, D.C. 52 pp. 35 cents. Discounts on quantity orders. Order from the Council, 1201 16th Street, NW., Washington 6, D.C.

Among the new material in this revised edition is a section on health services for handicapped children and one on health services in physical education.

A GUIDE FOR THE STUDY OF PERINATAL MORTALITY AND MORBIDITY. Council on Medical Service, American Medical Association, 535 North Dearborn Street, Chicago 10. 1959. 31 pp. Available on request from the Council.

A "flexible basic program" for hospital, city-county, and State perinatal study committees aiming to reduce mortality and morbidity in the period before, during, and soon after birth.

SYMPOSIA ON CHILD AND JUVENILE DELINQUENCY, presented at the American Orthopsychiatric Association. Psychodynamics Monograph Series. Station L, Washington 20, D.C. 1959. 364 pp. $10.

Proceedings of five symposia on delinquency held during 1949–53.

HERE AND THERE

State Legislation

Among State actions affecting children, taken in the 1959 legislative sessions, were the following:

In **Alaska** a new State department of health and welfare was created to take the place of three Territorial departments—of health, of public welfare, and of juvenile institutions—and in addition to administer certain adult institutions and probation and parole functions.

In **Arkansas** the State board of health was given authority to regulate use of radiation. Use of shoefitting devices involving fluoroscopic, X-ray, or radiation principles was prohibited.

In **California** the legislature appropriated $90,000 for the State to participate in an intercounty adoption program. It also authorized juvenile courts to commit children to the county welfare department.

The legislature also appropriated $32,000 for diagnosis and treatment of childhood nephrosis, thus adding this crippling condition to the State program for crippled children, and provided $34,965 for pilot projects for the treatment of children with epilepsy and for a study of the feasibility of including such children in the crippled children's program. Other new acts make it unlawful to coat toys with injurious substances; forbid all but licensed persons, or technicians under their supervision, to operate X-ray or fluoroscopic equipment; and require danger warnings to be printed on plastic garment bags.

In **Colorado** the legislature provided that after July 1, 1960, no child under 7 years is to be committed to the State children's home unless such commitment shall be approved by the superintendent of the home.

In **Connecticut** the legislature authorized the department of education to provide special services for emotionally disturbed children and appropriated funds for planning and purchase of land for a mental health center in New Haven.

In **Idaho** the legislature required public school districts to provide for the education of handicapped children who are not being educated or are not eligible for education in State-supported schools. The State department of public assistance was given authority to accept or refuse commitments of delinquent or dependent children.

In **Indiana** a Governor's youth council was created as a new State department, and a committee established to study the problems and needs of emotionally disturbed children as a step toward program formulation. County public welfare departments were required to make a public record which itemizes vendor payments for medical care but does not in any way identify recipients under the Aid to Dependent Children's program.

The Indiana Commission for Physically Handicapped Children was dissolved, and a larger Commission for the Handicapped concerned with handicapped persons of all ages created. A rehabilitation unit to implement the work of the commission—which is coordinative, informational, and educational in nature—has been established within the State board of health.

In **Kansas** provision was made for the training and education of the deaf-blind, in the State or in another State.

In **Maine** the legislature prohibited work at night (9 p.m. to 7 a.m.) for children under 16. All but two States now have some legislative prohibition of this type.

In **Minnesota** the responsibility of the juvenile court over termination of parental rights and appointment of guardians was clarified and, in counties with juvenile court judges who have been admitted to the practice of law within the State, the juvenile court was given jurisdiction over adoption. The counties were required to provide probation services to juvenile courts or secure them through the State Youth Conservation Commission, with the State paying each county of not more than 100,000 population 10 cents per capita to cover the costs. Other measures transferred the commission to a newly established department of corrections; provided for foster care placement of delinquents released from institutions; and specified the functions of county child welfare boards in administering programs of social services and financial assistance to children.

Other Minnesota legislation permitted the State department of health to establish a human genetics program for counseling, education, and research on physical and mental abnormalities related to heredity; authorized admission of State-supported handicapped children to facilities other than the State hospital when the hospital cannot provide care; and provided for instruction and services for handicapped children.

In **Missouri** under a new law the State crippled children's agency, instead of a county court, now determines who may receive services under the crippled children's program. The same law has broadened the definition of a crippled child, so that the agency may extend services to children with conditions besides those requiring orthopedic or plastic surgery.

In **New Mexico** the legislature directed the State Department of Health to set up regulations requiring the immunization of all school children against diseases "deemed to be dangerous to public health." (Diphtheria, pertussis, tetanus, poliomyelitis, and smallpox have been so designated by the department.) The legislatiure also directed the State Department of Health to regulate procedures concerning the use of radioactive material (excluding control of kind and amount of radiation used by licensed practitioners of the "healing art"); required registration of sources of radiation; and forbade the use of shoefitting devices involving radiation. Another new health measure set a penalty for abandoning a refrigerator unless its door is removed, locked, or sealed.

Other New Mexico legislation required adoption proceedings to be carried out in private, put the State youth commission in the Department of Education, made it unlawful for fathers, or mothers, to fail to support a minor child insofar as possible, empowered juvenile courts to transfer felony cases of persons over 14 to criminal courts, and raised amounts of civil damages payable by parents for children's malicious or willful actions. Appropriations for probation services were increased.

In **New York** the legislature authorized local public welfare officials to provide care for unmarried mothers away from their hometowns before and after the baby is born, without notifying or billing the woman's parents or anyone else in the hometown; and to place a child for adoption outside the State in States where officials agree to supervise the adoptive family until the decree is granted. The legislature also provided that a child whom the court finds to be "permanently neglected" can be adopted without the parents' consent, specifying that the neglect finding can be made if the parents have failed for more than a year to maintain contact with him and plan for him, though physically and financially able to so and though an authorized agency has attempted to bring about better relations between the child and his parents.

Other New York legislation authorized establishment of programs for early detection and treatment of behavior problems in schoolchildren and allowed counties to make arrangements with each other for provision of detention care. The effective date of the Youth Court Act, passed in 1956 (see CHILDREN, July–August 1956, p. 153), was postponed, for the second time, to April 1, 1960.

In **North Carolina** the legislature required all children to be immunized against poliomyelitis before entering school.

In **North Dakota** the legislature authorized the use of public funds for foster home care for young people paroled from the State training school, and appropriated $150,000 for a children's psychiatric center. It provided for sending deaf-blind children out of the State for training. It also reduced the upper age limit for compulsory school attendance from 17 to 16. The legislature also provided for a study of the State training school by the legislative research committee.

In **Oklahoma** the State commission for crippled children was abolished and the crippled children's program transferred to the department of public welfare. New laws created a State child guidance board and authorized counties with health departments to conduct child guidance programs. The legislature also provided for a radiation advisory committee.

In **Oregon** the State welfare commission was authorized to establish public agency adoption services. The legislature also created a State board of hearing examiners to license qualified persons for fitting hearing aids and directed the State board of health to establish qualifications for the licensing of physical therapists.

In **South Dakota** the legislature outlawed switchblade knives. It also authorized the superintendent of the State hospital to admit for physical and psychological observation anyone suspected of being mentally retarded and to keep him at the hospital for a month upon payment by his parents for the service. Responsibility for persons on parole from the State training school was transferred from the school's superintendent to the director of probation and parole. The State's total monthly payment under the ADC program was set at not more than $35 multiplied by the number of recipients. An appropriation of $3,500 was approved for a Governor's committee on children and youth.

In **Tennessee** the legislature provided for establishment of a rehabilitation center, including a hearing and speech center, at Nashville. Amendments to the adoption laws required that natural and adoptive parents be present in court when a child is surrendered for independent adoption, required adoptive parents to have lived in the State the entire year preceding the adoption petition, and made the child for whom an adoption petition has been filed a ward of the court until the adoption is final or legal guardianship approved. The legislature also authorized juvenile courts to hold open hearings and to set fines up to $50 for traffic violations and permitted local boards of education to lower the age for compulsory school attendance from 16 to 15 for children whose attendance results in detriment to good order and discipline, impedes the instruction of other children, and is not of substantial benefit to themselves.

A change in the Tennessee licensing law brings under the licensing requirements all institutions, which either "primarily or incidentally" provide full-time care outside their homes for seven or more children under 17 years of age, and broadens the definition of day care centers (also subject to licensing) to centers which care for children at any time within a 24-hour period.

In **Texas** the legislature ordered removal from the public part of birth certificates the item showing whether or not a child is legitimate. It also created a coordinating commission for State health and welfare services and provided for care and education within or outside the State of persons under 18 who are totally deaf and blind, or totally blind and nonspeaking, and authorized a program to prepare preschool children with hearing loss to enter the State school for the deaf.

In **Utah** the legislature provided for appointment of a State director of special education and for establishment of day care centers for handicapped children.

In the **Virgin Islands** the legislature passed an act authorizing the department of social welfare to establish and administer day care centers and made a $50,000 appropriation for the purpose, contingent upon the availability of funds.

In **Washington** the legislature provided for State aid to less populated counties in establishing and increasing probation services.

In **Wyoming** the legislature made it possible for a parent who is a minor to relinquish a child for adoption. It also established a school for the deaf separate from a school for the blind.

Alaska, Arkansas, Indiana, Missouri, Oklahoma, South Carolina, South Dakota, and Vermont adopted the Mental Health Compact, bringing to 21 the number of States within the compact. Members of the compact agree to waive State residence requirements for admission to State mental hospitals for any of the States which have adopted the compact.

—**Sarah L. Doran**

Congressional Action

The 86th Congress has appropriated $46,500,000 for the fiscal year ending June 30, 1960, for grants to the States under the three maternal and child welfare programs administered by the Children's Bureau—$3,000,000 more than last year's initial appropriation for the programs. The 1960 appropriation includes $17,500,000 for maternal and child health services, $16,000,000 for services for crippled children, and $13,000,000 for child welfare services—an increase of $1,000,000 for each of the three services. The appropriation for maternal and child health services is 81 percent of the sum authorized by the Social Security Act, as amended; for services to crippled children, 80 percent; and for child welfare services, 76 percent. As in previous years, $1,000,000 of the maternal and child health appropriation is earmarked for special projects for mentally retarded children.

A supplemental appropriation to the 1959 budget provided $1,500,000 for services to crippled children, to be used only for services for children with congenital heart disease. These funds will remain available through the fiscal year 1960.

The Congress has also appropriated $2,300,000 for Children's Bureau salaries and expenses, an increase of $128,000 over last year's amount; and $200,000 to go toward expenses for the 1960 White House Conference on Children and Youth, a $50,000 increase over the amount appropriated for Conference preparations last year.

. . .

The President approved a House joint resolution changing the date of Child Health Day from May 1 to the first Monday in October, effective for the calendar year 1960.

. . .

Before adjourning its first session, the Congress extended for a third year the provisions of an act passed in 1957 permitting alien children who are eligible orphans to come into the United States on special nonquota immigration visas if the children had been adopted abroad by American citizens, or were coming to this country for adoption here. (See CHILDREN, November–December 1957, p. 238.) The previous act permitted issuance of nonquota visas up to June 30, 1959; the new one (Public Law 86–253, September 9, 1959) extends that permission to June 30, 1960.

The new law adds provisions under which the adopting couple are required to file a petition for the child's visa with the Attorney General of the United States containing information and documentary evidence to establish that they will care for the child properly if he is admitted and (if he has not already been lawfully adopted abroad) that they will adopt him in the United States, meeting the preadoption requirements in the State of the child's proposed residence. If, "after an investigation of the facts in each case," the Attorney General determines that the facts stated in the petition are true and that the petitioners are persons of "good moral character," the petition will then be granted.

White House Conference

The final draft of the program for the 1960 White House Conference on Children and Youth was adopted by the Conference's national committee in late October. This provides for a dual focus: "The World Around the Young" and "The Young in the World." Thus the discussions of the 18 concurrent daily forums, each with a separate area of concern (See CHILDREN, July–August 1959, p. 156), will stem from these two approaches, nine of them focusing on the outside factors influencing the young, and nine on the inward needs and problems of children and youth.

On their first morning, the five concurrent theme assemblies, with which 3 days of the 6-day Conference will begin, will have an "inward" focus—appraisal of the ideals and values of today's youth in their changing world, while the theme assemblies for the other 2 days will be concerned with outside influences: (1) assessing the impact of today's economic, social, and cultural factors on youth; and (2) youth's adaptation to the changes brought by science, technology, and population pressures.

The 210 work groups of the Conference will each focus on a specific aspect of topics such as: health (physical and mental); child care; education; community services involving children; handicapped children (physically and mentally); adoption; recreation; values and ideals; teenage problems; juvenile delinquency; youth employment; citizenship; relationship to adults; impact of mass media; rights and responsibilities of children; changing conditions affecting children; working mothers (implications for children); unwed teenage mothers; population shifts (effect on children); minority group problems; and family life.

The work groups will be interdisciplinary in make-up, with members of various professions, laymen, and youth delegates being assigned to each. Well before the convening of the Conference each delegate will receive a copy of the program to enable him to designate several work group subjects of most interest to him. From these choices the work group assignments will be made. Among other materials to be sent to each delegate prior to the Conference will be a "fact sheet" of background information pertinent to his work group's subject.

State committees have contributed to the program preparation by indicating their areas of chief concern. A preliminary report of material sent to the Conference secretariat in Washington shows that juvenile delinquency prevention, treatment, or both, is the most prevalent concern, being listed by 39 States as a major interest. Next comes the diagnosis and treatment of emotionally disturbed children a major concern in 32 States. The training and treatment of retarded children comes third, with 29 mentions. Fourth (25 States) and fifth (24 States) are respectively religious and spiritual life, and establishing values and ideals in children. At the bottom of the list, a major concern in only one State each, are problems of radiation hazards, rural-urban migration, and teenage drinking.

As a contribution toward program planning and followup, representatives of 267 of the 464 member agencies of the Council of National Organizations met in Washington for 2 days in mid-September to identify issues relating to the Conference theme, to propose ways of stimulating interest in the Conference, to discuss what they would like to see come out of the Conference, and to define the roles of national organizations in followup.

The discussions took place in 10 work groups which considered these problems in the light of education, health, values and ideals, child care, leisure time activities, teenagers, handicapped children, youth in conflict, children and youth of minority groups, and the effect of changing social and economic conditions. Among the many issues they identified as important for Conference consideration were: identification of American values and the differences between teaching and practice; a reexamination of the role of the public schools in American society; how to achieve health supervision for all children; how to retain the basic human rights for children in the Aid to Dependent Children program; how to provide teenagers with opportunities to do "real things"; and how to make our institutions flexible enough to meet the needs of minority groups.

Schools

The Nation's school and college enrollment—public and nonpublic—increasing for the 15th consecutive year, will reach an all-time high of 46,480,000 in the school year 1959–60, an increase of 1,940,000 over the 44,540,000 enrollment for the 1958–59 school year, according to the Office of Education.

Reports to the Office indicate that public elementary and high schools opened with a shortage of at least 130,000 classrooms.

Last fall's enrollment in public elementary and secondary schools was 1,843,000 in excess of normal school capacity, and this year's is expected to increase by 1,110,000 in the grades from kindergarten through the 8th, and by 260,000 in the 9th through the 12th. With 30 pupils per room for elementary schools and 25 for high schools, increased enrollments alone require an additional 37,000 rooms in elementary schools and 10,400 in high schools—a total of 47,400. In addition, the schools will need 16,800 new classrooms to replace those that for various reasons have become unusable, the Office estimates. This means a total additional need of 64,200 classrooms just for increased enrollments plus current replacements.

Last year the States estimated that 68,400 classrooms would be built by this fall. If those 68,400 classrooms have been built, last year's shortage—140,500—will have been reduced by 4,200, leaving the present estimated shortage at 136,300.

Mental Health

January 1960 marks the beginning of World Mental Health Year, sponsored by the World Federation for Mental Health with the purpose of focusing scientific attention on the problems of promoting mental health in the world today. Actually the five projects selected for main attention are expected to take 3 or 4 years to complete. They are: (1) a study of childhood mental health, especially in relation to current influences throughout the world that affect family functioning for better or worse; (2) surveys of attitudes toward mental disorder; (3) a study to determine methods for teaching mental health principles in professional education; (4) a study of the effects of interpersonal relationships in work situations; and (5) a study of the psychological problems of migration.

All of these projects will be chiefly field rather than laboratory projects, each having a coordinator and a team of staff members who will evaluate the pertinent literature, consult with professional persons in various countries, conduct factfinding surveys, and hold regional conferences and teaching seminars. Their purposes will be to establish the facts on which improved services can be designed, to inaugurate action wherever possible, and to evaluate the results of such activity.

Plans are to finance the projects through contributions from foundations, voluntary organizations, and governments, though only a small portion of the $2,500,000 estimated cost has as yet been received. The projects will proceed as the money is forthcoming.

Adoptions for Indians

For the past year the Child Welfare League of America and the Bureau of Indian Affairs, U.S. Department of the Interior, have been carrying on a joint pilot project to provide adoption services to American Indian children. The project developed out of concern over the number of totally dependent Indian children living on Indian reservations for whom no adoptive homes can be found on the reservations or within their own States. Its purpose is to explore adoption possibilities for Indian children off the reservation through the out-of-State placement of 50 such children, preferably infants.

Two private adoption agencies in Eastern States have agreed to find adoptive homes for Indian children who are free for adoption and considered adoptable, without regard for racial matching. Results of these placements will be studied and evaluated as the basis for developing a permanent interstate plan for the placement of Indian children needing adoption.

The two adoption agencies participating in the project are the Louise Wise Services, New York City, and the Children's Bureau of Delaware, Wilmington, Del. At least one additional agency is expected to participate.

Since other League agencies have also expressed an interest in placing Indian children for adoption—especially older children— a plan has been worked out for the project director to act as liaison between placement agencies and agencies responsible for adoptable Indian children, whether or not the agencies are participating in the study.

At the present time the project is operating in 13 major reservation areas in Arizona, Montana, Nevada, North Carolina, and South Dakota. Factors in the selection of these areas have been:

1. The presence within the reservations of children needing adoption.
2. The limited nature of the adoptive opportunities within the State.
3. The legality of out-of-State placements for adoption under the State adoption laws.
4. The availability to the reservation of a trained child welfare worker to work with the child and the natural parent.
5. The availability of a Public Health Service arrangement for medical services to Indian children and their families.
6. Interest in the project on the part of public and private social agencies in the respective States.

Prior to the initiation of the project inquiries were made, with generally favorable response, into the attitudes of Indian tribal leaders and the national voluntary organizations concerned with Indian affairs toward the adoption of Indian children outside their tribes.

Since the first several months of the project were spent in exploration, planning, and organization, the actual transfer of children did not begin until December 1958. So far eight children have been released for adoption through the project, six of whom have already been placed in adoptive homes.

Director of the project is Arnold Lyslo of the Child Welfare League staff.

Public Assistance

State reports to the Bureau of Public Assistance for a sample month late in 1958 indicate that nearly half of the more than 745,000 families receiving payments under the Aid to Dependent Children program were not receiving enough total income to meet their needs as determined by their States' assistance standards. In these families, located in 39 States, the income shortage averaged $39 a month. For 100,000 of them, the monthly income was short by $50 or more.

Fifty-five percent of all the families on ADC had no income except public assistance payments. For the families that had other income, the most frequent sources were wages earned by the mother (13 percent of all the families) and contributions from the father, who was not living in the home (12 percent).

Of the mothers who were in the home, about one-sixth—103,000—were employed, one-third of them full time. Cash earnings averaged $48.47 a month. Their families included 87,000 children under 6 years of age and 165,000 children from 6 to 12. Arrangements for care of the children—mainly in the home—while the mother was working had been made for 89 percent of those under 6 and 78 percent of those from 6 to 12.

The median age of the 2,142,000 children in all families receiving ADC payments was 8.4 years. Three-fourths of the children were under 13.

The figures do not include data from Vermont or the Virgin Islands.

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As a step in planning for a family service unit in its public assistance division, the District of Columbia Department of Public Welfare has contracted with the Catholic University School of Social Service for an analysis of a 5-percent sample of the more than 1,000 cases of troubled families that have been classified by its social workers as amenable to intensive casework treatment. Purpose of the study is to identify the families' problems to evaluate their potentialities for treatment, and to indicate possible goals and methods of treatment.

For Health

A 5-year research effort to find the causes of cerebral palsy, mental retardation, and other neurological defects is being carried on by the National Institute of Neurological Diseases and Blindness, Public Health Service, in collaboration with 16 hospitals and universities in 12 States.

On the basis of results of smaller studies suggesting that such defects may be caused by infections, injuries, or other unfavorable happenings that occur during the mother's pregnancy or during the birth process, the project will compare the history of such incidents with the child's later condition.

Beginning in early pregnancy and continuing into the child's early years, each incident known to the collaborating hospitals will be studied by obstetricians and pediatricians and by specialists in at least a dozen other medical and scientific disciplines, and will be recorded in detail. Later the records will be studied in connection with any neurological or sensory defects found in the child.

The study, which has been in preparation for 2½ years, will involve 40,000 women and will cost approximately $4 million annually.

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The Children's Bureau is recommending that every child under 1 year of age be given a four-way simultaneous vaccination against poliomyelitis, diphtheria, whooping cough, and tetanus as well as a separate vaccination against smallpox. The message was carried in the Bureau's exhibit at the 1959 meeting of the American Public Health Association at Atlantic City in mid-October, and is the subject of a recently issued leaflet "Protect Your Child," which can be obtained from the Bureau without charge on request.

The leaflet explains that through a series of injections of a new quadruple vaccine a child can be protected simultaneously from polio, diphtheria, whooping cough, and tetanus. It recommends that the child be given the first of these injections when he is 1 to 2 months old; a second, a month later; a third, after another month; a booster when he is 16 to 18 months old; and another booster against three of the diseases—whooping cough, tetanus, and diphtheria—when he is 3 or 4 years of age.

If the child has already been inoculated against whooping cough, tetanus, and diphtheria but has not been protected against polio, he should be given two injections of polio vaccine a month apart; after 7 months, a third injection; and a fourth, 1 year later, according to the leaflet. It recommends vaccinating children against smallpox at 5-year intervals beginning in their first year.

Spanish-language editions of three mental health leaflets issued by the National Association for Mental Health are now available in Spanish-speaking communities in the United States and South American countries. The leaflets are: "What Every Child Needs for Good Mental Health," "Some Things You Sould Know About Mental and Emotional Illness," and "Mental Health Is 1, 2, 3." Translated by the Bureau of Mental Hygiene of the Puerto Rican Department of Health, the leaflets are being distributed by the Association, 10 Columbus Circle, New York 19.

Juvenile Delinquency

At the request of the Appropriations Committees of both Houses of the 86th Congress, the Children's Bureau and the National Institute of Mental Health have been conducting a joint study as the basis for proposals to the Congress on what can and should be done in the field of juvenile delinquency. A joint report will be presented to the Congress early in the second session.

In carrying out its part of the study, with the help of funds allocated for the purpose by the National Institute of Mental Health, the Children's Bureau has been seeking information and advice through questionnaires and conferences from a variety of sources, including juvenile courts, police departments, voluntary social agencies, State departments of welfare, and university departments of sociology.

Among the topics on which the Bureau is securing information are: (1) the nature and size of the problem; (2) the quantity, quality, effectiveness, and cost of official control and treatment agencies; (3) the character, source of funds, and effectiveness of programs specifically aimed at reducing delinquency; (4) training resources and output; (5) sociological theory and its application to programs; and (6) present Federal and State contributions to the prevention, control, and treatment of delinquency.

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An experiment in treating juvenile delinquents without sending them away from home is being carried on in Provo, Utah, under the auspices of Brigham Young University. The treatment takes place in 2-hour rehabilitation sessions held 5 days a week outside school hours. The group rehabilitation process goes on for a few months, in contrast to the longer periods some delinquents spend in training schools. Besides group discussions, sessions are devoted to athletics, handicrafts, vocational training, and, when indicated, remedial schoolwork. At the same time juvenile-court officers work with the boys' families and help find jobs for some of the boys.

The Ford Foundation recently granted funds to the university to continue the experiment for 6 years and to evaluate its effectiveness. A member of the sociology faculty will compare the conduct of boys who have participated in the experimental program with the conduct of those who have been treated with the probation or correction procedures usual in Utah.

• • •

A 5-year demonstration project to guide schools of social work in preparing students for correctional social work has been begun by the Council on Social Work Education with a grant from the Ford Foundation. The plans provide for a full-time consultant, who may call upon a panel of experts in the field of corrections, and an advisory committee representing correctional institutions, probation- and parole-officer groups, and educational institutions. The council will also attempt to stimulate social work training of probation and parole personnel through exchange of information and through research.

Against Polio

One of the most important unresolved problems in relation to the use of live virus vaccine against poliomyelitis, according to a committee created by the Public Health Service to study such problems, is lack of proof that the community of nonvaccinated persons is free of danger from possible reversion of virulence in excreted virus.

The committee reported to the Surgeon General late in August on its review of the development and field use of three sets of live attenuated poliovirus strains that have been proposed for use as oral vaccines and on the technical problems involved in setting up specifications for the vaccines' production.

Other major problems still to be solved the committee identified as: the significance of increased neuro-virulence for monkeys of virus excreted by vaccinated monkeys, as reported by a number of workers; the demonstration of adequate measures of effectiveness of live poliovirus vaccines, controlled in field trials involving large population groups; the development of standards to determine the possible presence or absence of stray agents in the vaccine; the assurance of the vaccine's potency through the establishment of studies to demonstrate the production of specific antibodies in 90 percent or more of inoculated susceptibles.

The committee noted that no evidence has been reported to indicate that any of the vaccines harmed the individuals to whom they were administered, although the thoroughness with which the observations were made had varied in different studies, and that evidence indicates that under some circumstances the simultaneous administration of all three types of virus may be effective.

The Public Health Service is urging every person under 40 to protect himself with a complete series of the Salk (killed virus) vaccine until the technical problems of safety, effectiveness, and production of live virus vaccine have been worked out—a time estimated by the Surgeon General to be about 2 years.

Foster Care

Difficulties in finding good foster family homes for children were reported recently to the Virginia Department of Welfare and Institutions by a number of local welfare departments. Forty-four reports on the subject were received as supplements to a statistical study made by the State department of the physical and social characteristics of homes which had accepted or were ready to accept children from the 125 local welfare departments.

Among the characteristics of foster homes reported on in the statistical study were the following: home ownership; number of rooms; age, marital status, and employment of foster parents; own children of foster parents living in the home.

Most frequently cited as a difficulty in home finding was the recruitment of families to care for adolescents, especially boys. Few families wanted to take a child over 12, particularly one who has behavior problems, or is mentally retarded, or is a Negro. Some families, the departments reported, considered the board rate too low to permit them to maintain older children; some considered the rate too low even for taking younger children. Young children with special needs were also hard to place, in some departments' experience.

Among other obstacles mentioned were lack of staff time for recruiting and investigating homes and for supervising children in foster care and the distances of many of the homes from department offices, thereby requiring too much staff time to be used in traveling.

Two local departments recommended that a forestry camp or similar facility be provided for older boys who are not benefiting from schooling and who need counseling and guidance.

Mental Retardation

At the instigation of the division of maternal and child health of the Maine Department of Health and Welfare and the Pineland Hospital and Training Center, located at Pownal, Maine, the first International Medical Conference on Mental Retardation was held in Portland, Maine, for 5 days in late July. More than 600 professional persons from 33 countries and 40 States of the United States attended. The conference was financed with a combination of State and Federal funds and private foundation grants.

With the focus on new knowledge about the etiology of retardation, the conferees heard and discussed 35 scientific papers reporting on research into various pathological conditions associated with mental retardation. Included were reports on: recent findings of chromosomal abnormalities in mentally retarded persons; inborn metabolic errors arising from abnormalities in enzyme function; malformations produced in animals by abnormal feeding, poisons, or other methods of damage; relation of breathing in the newborn to the acid-base equilibrium and its importance for asphyxia; pathological findings in the brains of mentally retarded patients; and the effects of prenatal infections on mental and physical development. Proceedings, including all the conference papers and discussions, will be published soon.

Before adjourning the conferees set up a permanent committee to arrange for similar conferences in the future and decided to hold the next at Vienna, Austria, in 1961. The committee members come from Argentina, Austria, Denmark, France, Germany, Great Britain, Italy, Poland, Sweden, and the United States.

BOOK NOTES

THE ONSET OF STUTTERING; research findings and implications. Wendell Johnson and associates. University of Minnesota Press, Minneapolis. 1959. 243 pp. $5.

After more than 20 years of research on stuttering and nonstuttering children and their parents by the State University of Iowa's speech pathology center, the author of this book and his associates report their findings that children who are regarded as stutterers are essentially normal physically and emotionally and that their speech problems originate in the attitudes of their parents toward the child and toward the stuttering.

In the study, which involved 500 children—half of them stutterers and half nonstutterers—the investigators found that the parents of the stutterers were more demanding of fluency in the child's speech, that they were more dissatisfied with their children and with each other, that they had higher standards of child development, and that they seemed to think, feel, and behave in ways calculated to make for tension in the home. Characteristically the stutterer began his stuttering between the ages of 3 and 4.

FAMILY WORLDS; a psychosocial approach to family life. Robert D. Hess and Gerald Handel. University of Chicago Press, Chicago. 1959. 305 pp. $5.

The day by day emotional lives of five "ordinary" families are analyzed in this book by two sociologists, who selected them as representative of the families in a much larger study group. All, the authors note, were without excessive conflicts. The authors' purpose was "to explore the complexity of the family's emotional life and to introduce and apply concepts for the understanding and study of everyday, nonpathological American urban families."

Each family was studied by means of interviews and tests, and by essays written by their members. In separate interviews each father, mother, and child was encouraged to discuss such subjects as the individual's view of the family as a whole; what the family members do at home and elsewhere and how they feel about their activities; the course of the family's development; how the parents deal with the children; and how the family members feel about one another. Test procedures included (1) interpretation and discussion of specified pictures by the family as a group and (2) sentence completion by each individual. Each parent wrote an essay on "The kind of person I would like my child to be"; each child, on "The kind of person I would like to be like."

In a summarizing chapter the authors discuss the five families in relation to the nature of the family members' mutual regulation, "family themes" or central concerns, the family's degree of "connectedness," family boundaries or "life space," and continuity of tradition.

RUSSIA'S CHILDREN; a first report on child welfare in the Soviet Union. Herschel and Edith Alt. Bookman Associates, New York. 1959. 240 pp. $3.75.

In this book two social workers report on what they observed during a 21-day visit to the Soviet Union in 1956. They discuss the social philosophy of the country in relation to child rearing, noting that the key principles in family life and the patterns of child care and education derive from established national purpose. Differences in approach to provisions for children in the United States and the Soviet Union they ascribe to a sharp difference in principles regarding parents' rights: In the United States the parents' rights are paramount, the State stepping in only in instances of neglect or incapacity, while in the Soviet Union the parents' rights are delegated from the State, which regards itself as the primary parent.

The book tells about many forms of public child care, such as day nurseries, kindergartens, summer camps, rooms in the schools for afterschool and evening care; supervision of children of employed mothers by neighbors; residential nurseries for children from 2 months of age up; homes for full-time care; and a variety of foster home arrangements. The authors also give their impressions of the extensive Government health and medical care program, gained from interviews with officials and visits to a few facilities in large cities, and note that prenatal care and health supervision of young children appear to have been meticulously developed.

A chapter is devoted to methods of dealing with delinquents and another to the treatment of children who are mentally ill.

Mr. Alt is director of the Jewish Board of Guardians in New York City, and Mrs. Alt is with the Health Insurance Plan of Greater New York.

HOW CHILDREN LEARN TO SPEAK. M. M. Lewis. Basic Books, New York. 1959. 140 pp. $3.

The growth of a child's ability to use words from his first sounds of discomfort to a command of his mother tongue is described by a British educator who has conducted intensive studies in the psychology and sociology of language.

Acknowledging the existence of individual variations, the author presents a general pattern of speech development in which the successive sounds which follow the vowel-like discomfort sounds are: the similarly vowel-like gurgles of comfort; the babbling response to adults' words and actions; the use of sounds to manipulate adults; and, eventually, the beginnings of imitation.

Learning to imitate, the author says, is a slow and laborious process; it includes a rudimentary stage, which is likely to last until the fourth month of life; a 4- or 5-month latency stage; and a stage of growing accuracy, which rarely begins until the end of the ninth month. The author also discusses the development of the child's understanding of the meanings of words in their limits and extensions, until language becomes for him not only a means of communication with others but also his most powerful instrument of thinking or "communicating with himself." As the child learns to use human language, the author concludes, he is also "learning to be human."

READER'S EXCHANGE

WRIGHT: *Obstacles and success*

The Florida Children's Commission has been wrestling with the problems involved in youth participation for several years. The participation of youth in our activities seems to us, as it does to Mrs. Wright, to be an essential part of our operation, but there is one consideration we have found which her article does not emphasize. ("Youth Participation in Community Affairs, by Sara-Alyce P. Wright, CHILDREN, July–August, 1959.)

This is the need for persuading adults to accept the fact that today's young people are ready for responsibility and can work with adults in reaching common goals. Most people cannot see the value of youth participation in anything other than the traditional service projects.

We have had both discouraging and encouraging experiences.

The commission operates in localities through volunteer county children's committees, composed of persons within the community who are known to have interest and experience in children's affairs. Two of the county committees have taken on young people as members and expect them to accept full membership responsibility, including listening and discussing. Yet some of our other most enlightened members have shown little interest in having youth participate fully with them. They have expressed the fear that their committees might lose their opportunities for frank discussion on matters which seem to them to be strictly adult concerns. However, they do approve of meeting with young people about problems related to community behavior and tangible services which are wanted or are already available.

One of our large city recreation departments is using young people most effectively this year. The administrator decided that youth could develop good leadership traits by actually conducting programs if given an opportunity. During the month of May a leadership course in recreation for all high-school students who wished to participate was conducted. The students came each Saturday for $3\frac{1}{2}$ hours and actually learned leadership methods and techniques for recreation programs. The participants are now serving as volunteers on the city playgrounds. Their punctuality, reliability, and conscientiousness have been most gratifying.

This is why we feel that success is a matter of education. Somehow, we must get across to the adults that many of today's youth are ready and eager to assume more responsibility than is usually given them.

Sylvia Carothers
Director, Florida Children's Commission, Tallahassee

RONEY AND WILTSE: *Too little and too late?*

In suggesting administrative policies that will more adequately meet family and community problems presented by today's ADC caseload, Mr. Roney questions the stopgap nature of assistance and service provided this group of fatherless families and suggests that through a program of general assistance families might be reached while the husband and father is still in the home. ["New Approaches to Aid to Dependent Children. I. Through Administrative Policies," by Jay L. Roney, CHILDREN, September-October 1959.] In New York State, where we are convinced of the importance of adequate general assistance we are emphasizing the provision of casework services to families receiving aid in a program of this type, hoping thereby to prevent physical and mental breakdown and forestall desertion.

Mr. Roney fails, however, to acknowledge the value of firm, consistent enforcement of support laws. Agencies that have conscientiously done this have located missing husbands and fathers, reunited many families, and secured regular, predictable support for wives and children, which has value far beyond the reduction in public expenditures. Mr. Roney also underestimates the need of some mothers without husbands to gain satisfaction and self-respect through employment. Even when such employment results in little saving to the public, it can bring important improvement in the mother's state of mind. Of course, with the mother's employment must go adequate plans for child care.

Mr. Wiltse, too, answers community critics of ADC. ["New Approaches to Aid to Dependent Children. II. Through Levels of Service," by Kermit T. Wiltse, CHILDREN, September-October 1958.] His proposals for getting appropriate services to the ADC recipients who need them are unorthodox and well worth trying. His suggestion of group meetings of ADC recipients runs counter to our concept of individualized treatment, confidentiality of relationship, and even the right to assistance. But it might work, at least for some families. Many families on ADC are isolated from the community because of long-term financial need, marital status, unsatisfactory living conditions, failure at school, at work, and at home. A group of mothers from an ADC caseload might easily become a grievance committee. Their limp acquiescence or passive resistance, called a "subclinical depression" by Mr. Wiltse, might change into an anxious aggression. But this could be a healthy step toward more independent living.

I doubt if ADC recipients are ready to serve on an advisory committee, for most of them are unable to communicate. But it might come later.

The prevalence of mental illness, or emotional disturbance, is startling in any ADC caseload. But these patients are "hard to reach." A psychiatric clinic within a public welfare department is well worth considering. The psychiatrist could diagnose and, where appropriate, treat recipients and also serve as consultant to staff in their ongoing relationship with these families.

Mr. Wiltse's proposal for classifying families by degree of need for services is a practicable approach to present-day staff and caseloads, but it involves a built-in danger—the expectation that families classified as needing only financial assistance will stay that way. A self-directing, apparently stable family may suddenly develop a problem needing skillful handling. Classifications would need periodic reconsideration and staff would need to be taught to detect early signs of deterioration. However, we must surely utilize available professional skills economically, and this requires careful selection of cases needing intensive service.

Margaret Barnard
Director, Bureau of Public Assistance, New York State Department of Social Welfare

Aggressive Administrators

We are in total agreement with Mr. Roney's suggestion regarding the improvement of our present administrative processes, if the goals of services as a criteria in ADC are to be achieved. We also agree wholeheartedly with Mr. Wiltse's emphasis on the importance of public welfare administrators' providing a more imaginative leadership in creating public understanding of the program by adopting an aggressive role through newspapers, radio, and television in attempting to dispel erroneous conceptions.

We hope that Mr. Wiltse's article will also stimulate agencies to initiate experiments with new approaches, studies, and evaluations, so that the highest standards for services to the children in the ADC program may be achieved.

Mae Wethers
Supervisor, Southern District Office, Cook County Department of Welfare, Chicago, Ill.

Focus on Children

In their articles Mr. Roney and Mr. Wiltse have both referred to the widespread criticism which is being leveled at the ADC program and which is resulting in restrictive legislation and policy. Mr. Wiltse is eminently correct in calling such legislation "a symptom of dissatisfaction with the answers social workers have thus far been able to provide to the public's questions about the program."

The major question which we need to resolve is why are our answers unsatisfactory. The attacks on ADC are not new. In my State we have had restrictive legislation since 1952, but the public was expressing dissatisfaction with the program long before. As social workers, the answers we have given have been factual and logical. Our demonstration projects have validated our beliefs that ADC is an orderly and economical method of helping children in need. We have proved that ADC does not cause or encourage illegitimacy. We have found that restrictive legislation and policy increase administrative costs. We have demonstrated that families can be helped through assistance and service to become more adequate. All this we know and all this we say, but to little avail.

Another approach we have used in answer to the criticism is to acknowledge frankly that among families receiving ADC are found social and moral problems distasteful to the community. At the same time we point out that we are only doing the humane thing in providing minimum essentials of care for the child while trying to help the family correct the problem. We ask our critics to examine with us what we want for the children of our Nation. We ask how we can afford not to see that every child has a home, food, clothing, and the opportunity for emotional, intellectual, and spiritual growth.

I have wondered if one reason for the failure of our appeal for support of an ADC program based on the needs of the child is because the law itself does not focus primarily on the child. The Federal act limits eligibility to the child "who has been deprived of parental support or care by reason of the death, continued absence from home, or physical or mental incapacity of a parent." (Sec. 406, title IV, Social Security Act, as amended.) With the condition of the parent being the determinant of whether a child receives assistance, we should not be surprised that the public, too, focuses on the parents.

If ADC were entirely a child-centered program, if it were expanded to include all children in need, regardless of family situation, I believe we would have greater public acceptance, for then the child and his needs could emerge from the welter of confusion surrounding the morals of the family. I believe that as a Nation we want our children to be given an opportunity for physical, mental, emotional, and spiritual growth.

Sara R. Caldwell
Chief of Social Administration, Mississippi State Department of Public Welfare

CRAIG: *Author's reply*

Amos Reed is so right in pointing out in his criticism of my article in the July–August 1959 issue of CHILDREN ["Reaching Delinquents Through Cottage Committees"] that committees can be no substitute for good staff. ["Readers' Exchange," CHILDREN, September–October 1959, p. 199.] At our school we believe it takes good staff to make effective cottage committees and conversely that the cottage committee system, as a dynamic method of working together, in turn makes better staff. We have learned that when weak, inexperienced, immature staff members can be accepted as team members rather than as "hired hands" by the mature, experienced, and professionally trained personnel, they are in a position to grow and learn and get added gratification from their efforts. Mistakes and weaknesses are not hidden but are in the open where they can be understood and worked with. We do not have a core of "experts," but rather a group of earnest people of varied disciplines who are teamed together, focusing their efforts on understanding and helping the children in their care and, at the same time, growing as team members and as persons.

Committees, like individuals, can be and are "conned" by the manipulators However, it is a harder job and the manipulator is often left "holding the bag."

I have presented the cottage committee system as one method of reaching delinquents, and not as "the answer." Its effectiveness depends upon the skills and maturity of the participants as well as their willingness and ability to work, learn, and grow.

Leila P. Craig
Clinical Psychologist, Boys Industrial School, Topeka, Kans.

YANKAUER: *Self-sufficiency a goal*

Alfred Yankauer ["Intercultural Communication in Technical Consultation," by Alfred Yankauer, CHILDREN, September-October 1959] has given a most perceptive discussion of some of the difficulties in providing technical assistance in another land as seen during his 2 years as WHO Visiting Professor of Child Health in Madras, India. My own experience would confirm most of Dr. Yankauer's views, but I must comment on the authoritarian type of teaching which he describes as typical. Such attitudes and practices are found in teachers and students in many countries in all parts of the world, but there is great individual variability.

The students of hygiene and public health from other countries whom we see at Johns Hopkins usually have or rapidly develop a mature, critical, and inquiring point of view, which augurs well for the sort of effort Dr. Yankauer describes. This has been especially characteristic of students from India.

The point that purely technical skills and information are best transmitted through teachers from a technologically underdeveloped country who have had a period of study and work experience in a technologically advanced society needs emphasis. The consultant can be an adviser and teacher of teachers, but the native-born is best qualified to impart the newer technics of knowledge to his own people. More than this, the so-called underdeveloped countries are rapidly reaching the point where they can do a better job of preparing many of their workers and technical people at home rather than abroad. One of our goals should be to help them to become increasingly self-sufficient in this respect.

Paul A. Harper, M.D.
Professor of Public Health Administration, Maternal and Child Health Division, Johns Hopkins University, Baltimore, Md.

MARTIN: *Health-welfare cooperation*

In reading Dr. Geoffrey Martin's article, "A Public Health Agency's Role in Adoption" [CHILDREN, July–August 1959], one is immediately startled to find that in Kansas the health department has responsibility for the issuance of licenses for foster homes, institutions, and adoptive homes—a function thought to be traditionally the responsibility of a social agency or more specifically the welfare department. Nevertheless, one must respect the contribution the public health field can and does make in the field of child welfare.

Here, in Connecticut, the contribution of the Bureau of Maternal and Child Hygiene in the State department of health has been invaluable in the total field of child welfare, and recently and more specifically in the adoption field. Not only did the bureau take the initiative in 1948 in showing concern about the health needs of the unmarried mother, but the social planning for the mother and child as well. After a period of joint planning and study with agencies, hospitals, and doctors, it established a program of payment for medical care on a limited and experimental basis for unmarried mothers in three rural counties, to be provided concurrently with social service by a social agency. A great deal of interpretation was done with the doctors, hospitals, councils of social agencies, and others concerned to assure the success of this cooperative relationship.

As a result of this project, when a new adoption law became effective in Connecticut on July 1, 1958—requiring adoption placements, except where the adoptive parents are related to the child, to be made through social agencies—doctors, nurses, and hospitals in these areas had no great difficulty in making appropriate referrals. Professional staff of the bureau has continued to be a very active and vital force in our adoption program in their work with doctors, hospitals, nurses, and others not only in the initial stage of interpreting the new adoption law, but also in helping to implement it.

I recommend a rereading of the article on "Medical and Social Care for Unmarried Mothers," by Hester B. Curtis and Alberta deRongé, in the September–October 1957 issue of CHILDREN as a companion piece to Dr. Martin's article.

These two articles clearly point out the contributions that can be made by health departments which, while their focus may be different, are still concerned with the total person in matters of health, mental and emotional well-being, and the social setting.

Marjorie G. Siskey
Chief, Welfare Services (Child Welfare), Connecticut State Welfare Department, Hartford

McFARLAND AND REINHART: *Unintentional effect*

I agree with John B. Reinhart and Margaret B. McFarland about the origin of motherly feelings, especially that the motherly capacities of a woman have their origin in her own childhood history. ["The Development of Motherliness," by Margaret B. McFarland and John B. Reinhart, CHILDREN, March–April 1959.] In my own hospital I have found out that 60 percent of the women bringing in children with psychogenic symptoms themselves came from an incomplete family. Studies of foster children and of children living in welfare homes showed me that even a higher percentage of mothers who had to leave their children to the care of strangers (not being able to care for them themselves) spent their own childhood in an incomplete family.

I want to emphasize how important the emotional stability and reliability of her husband is for a pregnant woman. About 60 percent of the fathers of babies born in my hospital also come from incomplete families. They are the ones who irritate their wives through emotional instability or by being against their pregnancy.

In spite of my being in almost complete agreement with the authors, I would like to raise the following question: Do they convey to the reader the concept that a mother who has difficulties raising her children has suffered privations without any fault of her own?

In my opinion, the idea is unintentionally conveyed—through the illustrative examples—that motherliness is a conscious accomplishment and that it is also a conscious accomplishment to become competent and mature. The article does not mention the unhappy, confused, overworked, or deserted mother, or, in contrast, the satisfied, happy, and healthy woman. It starts by saying that there are "good mothers." Further adjectives used are "mature" or "competent," and in contrast, "immature" and "frightened." Though the concept of "bad mother" is avoided, we must not overlook the fact that the reader will conceive this idea. The concept of "good mother" evokes the contrary even when we do not actually say it and when the word "good" is between quotes. Similarly, the example of the grandmother who did not properly care for her child shows a woman who is angry with her husband, but not the reasons she felt unhappy or deserted.

We should consider the fact that such articles are also read by mothers. If we want to avoid the danger that women ask more of themselves than they are able to accomplish, and in doing so arouse new fears and guilty feelings, then we should consider carefully what feelings this sort of description may arouse in women.

A. Dührssen, M.D.
Praxis der Kinderpsychologie und Kinderpsychiatrie, Berlin-Wilmersdorf, Germany.

U.S. GOVERNMENT PRINTING OFFICE: 1959

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

SELECTED FILMS ON CHILD LIFE. Compiled by Inez D. Lohr. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 376. 1959. 30 cents.

This list of more than 300 films which have been reviewed by the professional staff of the Children's Bureau is a complete revision of earlier Children's Bureau film lists. Redesigned for easier use it contains a subject index with 33 categories, an alphabetical list of films, and a directory of distributors. Each listing is accompanied by a suggestion regarding the type of audience for which it will be useful.

ACCIDENTS AND CHILDREN. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 48. 1959. 19 pp. 15 cents.

Notes types of fatal and nonfatal accidents that happen to children in different age groups and points out what parents can do toward preventing accidents at home, in the yard, walking on the street, and riding in an automobile. Warns against overprotecting children and lists six "safety goals."

MID-AMERICAN CONFERENCE ON MIGRATORY LABOR. President's Committee on Migratory Labor. 1959. 49 pp. Single copies available free of charge from the Secretariat, President's Committee on Migratory Labor, U.S. Department of Labor, or the Council of State Governments, Washington, D.C.

Includes the recommendations of the Mid-American Conference on Migratory Labor, held April 7–9, 1959, at St. Louis, sponsored jointly by the President's Committee on Migratory Labor and the Council of State Governments. (See CHILDREN, July–August 1959, p. 157.)

SOME GUIDE LINES FOR EVALUATIVE RESEARCH: assessing psychosocial change in individuals. Elizabeth Herzog. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 375. 1959. 117 pp. 35 cents.

This publication attempts to clarify the problems involved in research for evaluating efforts to bring about social or emotional change in individuals and the considerations to be weighed in approaching it. It also discusses some methods that have been tried for reaching solutions of these problems.

CONCEPTS OF MENTAL HEALTH AND CONSULTATION: their application in public health social work. Gerald Caplan. Supplementary chapters by Virginia Insley. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 373. 1959. 269 pp. $1.

Papers by a psychiatrist and a medical social worker, brought together in this report, explain the principles and techniques through which a social work consultant in public health can help other professional workers to solve their clients' problems. Mental health aspects of the mother-child relationship are discussed in detail.

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